THE OBSTETRIC GAZETTE.

Vol. VIII. — OCTOBER, 1885. — No. 10.

Original Articles.

OBSTETRIC RECORD OF A COUNTRY PRACTITIONER. TWELVE HUNDRED CASES.

A Paper Read before the Terrell Medical Society by

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I have selected labor and some of its consequences for my essay. In the first place I will give you some of the theories of, or a definition of Labor. By the term labor we understand the progress and final expulsion of the fetus and secundines from the uterus at the full period of gestation or pregnancy. Various have been the theories which have prevailed in different ages of the world respecting the immediate or exciting cause of labor.

Hippocrates and others believed that a child was born by its own efforts. Avicenna, an Arabian physician of the eleventh century, with great humility and devotion contents himself by saying: "At the proper time labor comes on at the command of God." At a more modern date Dr. Bard of New York City remarks: "We know no more of the immediate exciting cause of labor than we do why strawberries ripen in June and peaches in August." It is a law of nature established by the Creator, and that is all we know about it. My opinion is that labor takes place at the full period of gestation, because the product is fully ripe, and ready to be separated.

The female suffers more during child-birth in civilized society than she does in rude or savage life.

The Indians of our own country when a squaw finds her labor approaching retires alone to some secluded spot near a stream, and there without assistance remains till she is delivered; washes herself and child, and returns to her cabin and occupations. Parturition is not followed by the same degree of exhaustion in those women who are employed in manual labor in the open air, even in this country, as it is in those females who move in the "higher circles."

I will report my practical experience in obstetrics, as I have attended twelve hundred cases in fifty years practice, and have lost only two cases, both of placenta previa. I never had an occasion to use forceps, and

had only one case of laceration of the perineum that required an operation. She lived in this city, and was the smallest lady I ever attended in labor, and had the smallest pelvis. I have seen a few small slits in the os uteri and perineum which needed no attention. I believe that they were a benefit in after labors, left more room for the child to pass. Had they been operated upon, no doubt the same misfortune would have happened to them again.

I remained about twenty years in one location and attended some of the ladies as often as eight or ten times in their labors, and had every opportunity of ascertaining the extent of any injury which they might have received in subsequent labors. I have never seen the necessity of using forceps. I have been called four or five times in consultation to assist in using the forceps. When I examined per vaginam I found the parts were too rigid for the forceps, and prevailed on the attending physician to wait until the parts were relaxed, and the child would soon be born. I am of the opinion that if we had used the forceps we would have had a laceration of the os or perineum, or both. But by waiting, mother and child did well.

I was the only physician at Mushulaville, Miss., for twelve years. I remained there over twenty years. I found three white and several negro midwives. Physicians had never been able to get the obstetrical practice. At the first obstetrical case I was called to see I found an old negro woman attending a white woman, about six miles in the country. She had been there two or three days giving teas of gunpowder and fat pine splinters. The lady was having hard pains. The old negress told me the foot was presenting.

When I examined the lady I found the old negress had pulled down the rectum about six inches. I immediately informed the husband and friends of the condition of his wife. I gave a dose of morphine, she rested four or five hours, pains returned, and the labor was soon over. Mother and child both did well. I found the morphine acted like a charm before the pains returned. The parts were well relaxed and labor soon over. All the old midwives used similar teas, giving it for rigid os, not knowing what else to do. Whenever I met them I found the pains so severe and the os rigid, I would give a full dose of morphine and remain until they were easy and sleeping, and leave for home with word to send for me as soon as the pains would return. Sometimes it would be six or twelve hours, and she would say it was the easiest time she ever had.

When I was called to a case said to be in labor, and found the os rigid and hard, I gave a full dose of morphine and left, telling the husband as the pains return to send for me. I found the morphine had a very happy effect in relaxing the parts, with always an easy labor. Perhaps some one is ready to ask me me if I never had any cases that required assistance, I answer, yes.

When I find the os fully dilated and relaxed, pains weak, after waiting an hour or two and no improvement or increase in the pains, I would give a dose of fluid extract of ergot, which would soon increase the uterine pains and the labor would soon be over. If there is any danger of post partum hemorrhage, I always give a dose of ergot just before the child is born, and then apply a bandage and compress.

I never rupture the membranes until the os is well dilated. As soon as the head begins to press on the perineum I support it with the palm of my hand. Never press with much force.

I attended Mrs. C., aged 20, primipara, six miles in the country. She was in convulsions, had been four or five hours perfectly unconscious; labor went on regularly until the child was born alive. She never had any recollection of her labor, until within five or six hours after it was all over. Mother and child both did well.

I was called to another case seven or eight miles in the country, to see Mrs. R., age 18, in consultation with Mr. T. She was a very fleshy lady, primipara. She was in convulsions, unconscious, her pains were light, child dead.

I performed craniotomy (I bled both of my convulsive patients). The mother recovered and did well.

I was called to see a negro woman in labor. She was delivered of a large child with nearly all its bowels outside of its abdomen, passed out near the navel; child lived about twelve hours.

I have had three stillborn cases at full term; had to turn five or six, two breech presentations, three feet, five twin cases, two triplets.

After the child is born I never wait more than fifteen minutes before I deliver the afterbirth.

I have had a few cases of post partum hemorrhage, two in this town, one primipara; the afterbirth was nearly half the size of the child and adhered to the right side of the uterus. It required very hard pains to deliver it, she flooded profusely. I gave ergot, used cold water freely, and grasped the womb with considerable force with my hand. Still the flooding continued. I made her husband grasp the womb and use cold water until I could run to my office, about one quarter of a mile, to get some Munsell's salts, picked up a stick on my return (it was in the night), made a mop and wet it in a strong solution of the salts, washed out the womb twice and stopped the hemorrhage. Of course she was very much prostrated from the loss of blood. Under the use of iron tonics and nourishing diet she soon recovered. I was with her in two labors afterward. She did well.

Gentlemen, bear with me while I tax your patience awhile on the subject of lacerated cervix uteri.

Dr. Pallen said that "he believed it was absolutely necessary to sew up every case of lacerated cervix."

He believed everything was to be done by art in the way of cure, and nothing left to the *vis medicatrix naturæ*.

No part of the body, perhaps, has been so much sinned against as the os uteri, simply because it has been endowed with remarkable patience under injury. Dr. Marion Sims, whilst approving highly of the operation, chiefly advocated it in chronic cases which had resisted all other means of treatment. It was done frequently in New York, but he added "he thought it was now done sometimes where it was not necessary. It was only necessary when the mucous membrane was hypertrophied and ectrophied.

As Dr. Schroeder truly remarks in his "Manual of Midwifery:" The non-penetrating or incomplete lacerations of the uterus are almost always situated in the cervix, and those of slight extent arise in the physiological process of labor.

These rents do not give rise to special symptoms, and can afterwards be detected with great difficulty if at all.

Dr. J. G. Swayne said: I have myself always found, and I think most gynecologists will agree with me, that these unpleasant results will yield after several weeks of treatment, to rest, gentle aperients, alteratives and tonics, vaginal injections of cold water daily, occasional scarifications, and the application of caustics at first and the sulphate of zinc sticks afterward, about once a week.

I have never had occasion myself to pare the edges of these inevitable fissures and bring them together with sutures as Dr. Pallen recommends.

During the discussion Dr. Jardine Murray asks some very pertinent questions, viz., whether the operation recommended by Dr. Pallen ought to be performed when the cervix had been divided by the knife intentionally? a question which nobody appears to have answered, although during the last ten years the cervix uteri has been most freely divided in every direction with knives, hysterotomes and Kuchenmeister's scissors, by a great many who were present, for dysmenorrhœa, stenosis, and various flexions and other affections of the uterus, and perhaps by no one more often than by Dr. Marion Sims.

A few more remarks concerning a case of natural labor:

Let us not suppose that a partial acquaintance with the subject of midwifery is sufficient for the safe practice of the profession, for although in nine cases out of ten little or nothing is required to be done before the birth of the child, yet in the tenth such danger may occur as can only be arrested by the most prompt, decisive and judiciously directed assistance, and no person knows when called to attend a labor what character that labor may assume.

Much accurate knowledge is required to discriminate between the kind of cases in which assistance is proper, and to determine the time at which that assistance ought to be employed, as well as the proper mode of application.

I will close this paper, which is already too long, by comparing my obstetrical experience with such men as the following:

Mr. Kisch,	5,500	cases with	22 deaths.
Dr. N. West,	3,100	"	23 "
Dr. G. Jones,	2,000	"	16 "
Dr. Campbell,	1,500	"	13 "
Dr. Green,	1,500	"	12 "
Dr. McClintock,	1,000	"	12 "
Mr. Legge,	1,000	"	7 "
Dr. John Inabuit,	1,200	"	2 "

JOHN INABUIT, M.D.,
April 17, 1885. Terrell, Texas.

Society Reports.

OBSTETRICAL SOCIETY OF BOSTON.

Meeting of May 9, 1885.

The President, DR. A. D. SINCLAIR, in the Chair.

Dr. F. H. Davenport reported the following case of

POST-PARTUM HEMORRHAGE.

In August, 1884, I was asked to attend Mrs. A. in her confinement, which was expected within a few weeks. The physician who had attended her in her two previous confinements wrote the following: "On both occasions she came near dying of uterine hemorrhage. She faints as soon as the shoulders are born; and when you withdraw the body, which I found I had to do with my hands, as there were no more pains, the blood rushes out like a good-sized hydrant stream. I used ergot, ice introduced into the uterus and upon the abdomen, compression through abdomen and kneading. Raised the foot of bedstead, gave hypodermic injections of whisky, turned out clot after clot, and in about three hours obtained a firmly contracted uterus. Ether acts badly upon her uterine contractions."

August 22d I was summoned at seven o'clock in the morning. I found that she had had slight pains since early morning, and they were now beginning to be more frequent and harder. The progress, however, was slow, and it was not until twelve o'clock that the dilatation of the external os was fairly under way. At eleven o'clock I gave ten grains of quinine, and an hour later ten more. As soon as the os was fully dilated and the head coming down I gave a drachm of the fluid extract of ergot, and repeated the dose possibly ten minutes before the birth of the child. The patient nobly seconded me in my desire to have

her take as little ether as possible and only inhaled a few whiffs during the last pain. The child was born without any difficulty, and the uterus contracted firmly, giving me ample time to tie the cord and give the child to the care of the nurse.

With the very next pain the placenta came away, and this was followed by an alarming hemorrhage. The uterus became perfectly flabby under my hand placed on the abdomen, and I immediately allowed a stream of hot water, 120° F., to flow into the uterus from a fountain syringe. This was followed by contraction of the uterus which, however, was only temporary. I repeated the hot water, and finding this did not permanently check the flowing I alternated that with the introduction of ice into the uterus. After a few repetitions of the alternate heat and cold the uterus remained firmly contracted, and in from half to three-quarters of an hour after the birth of the child the patient could be moved from the cot on which she was delivered to her own bed. Only once, soon after the first gush, did the patient feel at all faint, and that was but momentary. She remarked that this was the only time she had ever heard the first cry of her baby. She did well until about the eighth day, when she had a rise of temperature, due undoubtedly to a slight phlebitis of the left leg. That delayed her getting up until the end of four weeks, and her leg was then somewhat stiff and painful.

I attributed the less profuse post-partum hemorrhage in this confinement to the use of quinine two and three hours before the birth, ergot as soon as the os was fully dilated, and the alternate application of heat and cold to the uterus.

Several German writers have reported cases where hot or cold water alone having failed, the alternate application of both at short intervals has been followed by a prompt cessaation of the hemorrhage.

Dr. Reynolds agreed with the reader in placing a high estimate on the value of the alternate use of heat and cold in checking post-partum hemorrhage; he believed, too, in the efficacy of electricity, and thought one should have a battery in readiness at every labor. He said that the late Professor Buckingham was thought to have saved two lives by the timely use of electricity in post-partum flooding. Ergotinine, in doses of five to ten drops, administered subcutaneously, was said to be of extreme value, and not injurious to the subcutaneous tissues.

The Diagnosis of Pregnancy.

Dr. Green read the report of a case which had presented unusual difficulties of diagnosis, the report having been prepared by Mr. H. S. Durand, of the Harvard Medical School, who had immediate care of the patient. The case may be briefly summarized as follows:

A negress, forty-three years of age, applied at the Boston Lying-in Hospital for out-patient attendance in her seventeenth labor. As the woman believed herself to be pregnant, and gave all the rational

signs of pregnancy, no physical examination was made until the element of time came in to throw doubts on the assumed diagnosis. The woman was sure, however, that she felt vigorous fetal movements, and there had been a progressive enlargement of the abdomen. A careful physical examination was now made, with the following result: The abdomen was symmetrically enlarged to the size of pregnancy at full term, and the umbilicus protruded somewhat. The breasts were large and secreted a watery fluid. The abdominal wall was very thick. Percussion gave no tympanitic resonance over the sides and to a less degree in front, but no more than might be expected from intestines distended with gas lying over the gravid uterus. On palpation no well defined uterine tumor could be made out; but movements resembling those of the fetus in utero were very well marked. The fetal heart was not heard; but the supposed fetal movements were very audible through the stethoscope. Thus far the physical examination threw no improbability on the diagnosis of pregnancy; but examination per vaginam revealed a cervix in no degree softened, and it was decided that the woman was in all probability not pregnant, unless still in the early months. Dr. W. L. Richardson kindly saw the case with Dr. Green, and agreed that the condition of the cervix ruled out advanced pregnancy, although the peculiar pseudo-fetal movements led him to examine the case with extreme care. As the patient objected to taking ether it was impossible at that time to determine the size of the uterus; but a course of carminatives and cathartics reduced the flatulent condition of the intestines and enabled Dr. Green to detect the fundus just above the symphysis pubis. A sound was then passed and the uterus shown to be of normal depth. It was then clear that the case was that of a woman who had passed the menopause, and who, being in vigorous health, has grown progressively obese. The peculiar movements were doubtless caused by a discharge of flatus from one coil of intestine to another.

Dr. Richardson said that the peculiar movements simulating fetal motion made him hesitate in reaching an opinion; he had never felt such movements before, except in a case of pregnancy. His diagnosis was based, like Dr. Green's, on the vaginal examination; the condition of the cervix ruled out pregnancy, unless it was still in the early months.

Dr. Reynolds asked the opinion of members as to the value of bi-manual examination in diagnosticating pregnancy in the early months.

Dr. Chadwick said he could usually detect pregnancy at the third month and sometimes at the second month by the bi-manual examination. He introduced his index finger into the anterior cul-de-sac, and his second finger into the posterior cul-de-sac, and depressed the uterus with his other hand; in this way he made out the axes of the uterus and from their relative changes formed his opinion, aided by his appreciation of the consistency, mobility and weight of the organ. In the early months

the uterus has usually a certain globular shape, which differs from the form of a uterus enlarged by a fibroid. In cases in which the uterus is retroverted and he is able to replace it, if it fails to retrovert in a week, he assumes the woman to be pregnant, even if the uterus is not sufficiently enlarged to enable him to judge by its size.

Dr. Richardson said he believed that the ease of making a bi-manual examination and the accuracy of its results were greatly enhanced by having the patient lie on her back with her legs extended, whereby the abdominal muscles are relaxed; if the patient draws up the legs and rests the heels on the bed or table, she instinctively supports herself in a manner with her heels and thus renders the abdominal muscles tense.

Dr. F. H. Davenport said that in the majority of cases he was able to determine the existence of pregnancy by the bi-manual examination at the third month, and in many cases at the second month. This was much easier when the patient had been under treatment before, and the size of her uterus was known. When that was the case a very slight increase in size could be readily made out. He thought that an increase in the thickness of the uterus, antero-posteriorly, was the first thing noticed, rather than an increase in the length. In the early months the examining finger feels the body of the uterus through the vaginal cul-de-sac in every direction more easily, and can make out the more globular form. There is also a peculiar elastic feel to the body of the pregnant uterus which is characteristic. It is difficult to describe, but is easily recognized after some experience. It is probably the same sign which has been observed by some Continental writers and spoken of as a softening of the lower segment of the uterus.

Dr. Strong said he felt very sure that pregnancy existed when he detected the peculiar, elastic resistance without a sense of fluctuation.

Dr. Green spoke of the importance of being able to recognize by vaginal examination the existence of pregnancy in the early months in hospital cases and others, in which corroborative evidence, known only to the patient, is purposely withheld from the physician in the hope that his manipulations, or local treatment of some genito-uterine affection, may produce abortion. He alluded to a case in point which he had recently seen at the City Hospital: a woman of suspicious appearance, complained of certain symptoms which might fairly be attributed to a displacement of the uterus, but denied all symptoms of pregnancy. Examination disclosed a retroverted uterus, apparently somewhat enlarged, the fundus imparting a peculiarly elastic feeling to the examining finger. On account of this sensation of elasticity no treatment was instituted, but the patient was kept under observation, and soon after the uterus was found to have undergone spontaneous reposition; it was then very easy to determine the existence of pregnancy from the shape and size of the uterus.

Dr. C. E. Stedman asked how much value was to be attached to the violet color of the introitus in the diagnosis of pregnancy.

Dr. Chadwick said the peculiar violet tint was of great value as a diagnostic symptom when it was present; but its absence did not, of course, exclude pregnancy.

Dr. Richardson had seen the blue color in women who had borne many children.

Dr. Chadwick said the blue coloration of the pluripara was of a different tint and was differently distributed. He had seen the blue coloration to which Dr. Richardson had reference in cases after excessive coitus. The peculiar violet tint, which he thought was of value in the diagnosis of pregnancy, was of deepest intensity, or perhaps only perceptible, on either side of and behind the meatus.

Puerperal Eclampsia.

Dr. F. H. Lombard, present by invitation, reported the following fatal case, and showed the uterus and its appendages:

The history of the patient from whom this uterus comes is breifly as follows:

She was thirty-four years old, well-built, of robust constitution and plethoric habit. Had been married a little over a year. Had never had any very serious illness. Up to a week ago was in perfect health, being at that time about six and one-half months advanced in her first pregnancy. During last Saturday afternoon she felt a light pain in the epigastrum. In the evening while visiting neighbors, this pain became so severe that she was obliged to return to her home and go to bed. At one o'clock Sunday morning she had a convulsion, no premonitary symptom, other than the constant epigastric pain, having shown itself in the meantime. At 3 a. m., she had a second convulsion, without having fully recovered from the unconsciousness produced by the first. She was coming out from this second convulsion at 3.30 a. m., when her physician arrived. Pilocarpine was immediately injected under the skin and profuse diaphoresis quickly followed. A teaspoonful of urine was drawn from the bladder and found to be heavily loaded with albumen. She had voided no urine since the previous afternoon. The pilocarpine was repeated once or twice at intervals and continuous sweating kept up by blankets and bottles of hot water. The patient remained in a state of coma and had a third convulsion at 7 a. m., lighter than the first two, neither of which had been severe. At 8.15 coma continuing, with increasing stertor, cyanosis and a sledge hammer pulse, sixteen ounces of blood was withdrawn from the arm. The patient improved in color and the pulse became less bounding; but otherwise the bleeding had no immediate effect upon the coma. There were no further convulsions, however, and during the forenoon the patient's condition improved so that at 2.30 p. m., when I first saw her, in consultation, she was suffi-

ciently conscious to open her eyes when spoken to, and had been able to be lifted on to the vessel in the hope that the bowels would move.

Although fully determined before reaching the house that the uterus should be opened at once, on seeing the improvement of the patient I was led to change my decision and agreed that so long as improvement continued it was the wisest to wait, standing ready to interfere at the first return of an unfavorable symptom. As the bowels had failed to respond to various cathartics administered during the forenoon, a quarter of a grain of elatrium was advised and given by the mouth. Nutrient enemeta were given at intervals through the afternoon, and the patient was apparently gaining. The appearance of improvement, however, was illusory, as there was no increased secretion of urine. At 6 p. m., the patient had a slight convulsion, the fourth in order, and the first since 7 a. m. At 8.30 p. m., I was again summoned. The patient was again unconscious, the pulse thready and the collapse threatening. Brandy was given subcutaneously and by the rectum, and the dilatation of the cervix was begun at once. The cervix yielded rapidly to digital dilatation, and in fifteen minutes fœtus and placenta were delivered. Profound collapse followed the emptying of the uterus, and was the result of shock, there having been no hemorrhage. Subcutaneous injections of ether and of brandy every fifteen minutes with postural treatment and hot bottles restored the circulation, and finally brought the patient out of her collapse, which lasted four hours, during most of which time no pulse was perceptible at the wrist.

The next morning the patient had a fair pulse, was able to recognize her husband and take nourishment by the mouth. Still the kidneys refused to act. A tablespoonful of urine drawn from the bladder showed under the microscope large quantities of fatty degenerated, renal epithelium; numerous hyalin casts (plain and waxy); large numbers of highly granular, with here and there an epithelial, cast; spiculated crystals of uric acid. During the afternoon coma again came on, and the patient remained unconscious from this time, death ensuing Tuesday morning at 11 o'clock, thirty-eight hours after delivery. At the autopsy, made by Dr. Gannett, twenty-four hours after death, both kidneys were found to be in a state of marked parenchymatous nephritis. Other organs normal. The uterus and appendages present nothing pathological. When asked how long before death the process in the kidneys, as shown by autopsy, had developed, Dr. Gannett replied that it had probably been going on for a week at least. I will add that the urine, which had been examined by the physician in charge once a month during the pregnancy (as a matter of routine and not because renal trouble was suspected) never showed an abnormal constituent; and the last examination was made two weeks before her death.

Dr. Lombard said he would like to submit for the Society's consideration two questions: first, whether it is advisable to give ether to a coma-

lose patient, when it is known that the kidneys are affected and the brain also, if the patient is perfectly still; second, whether it is advisable to empty the uterus without delay when the eclamptic seizure occurs between the fourth and seventh months; of the propriety of this treatment after the seventh month there is less doubt.

Dr. Ingalls could not see why ether should be used when the patient was comatose.

Dr. Hodgdon said he controlled the first symptoms of restlessness with chloroform, which he thought was preferable to ether; but he saw no reason to give an anæsthetic when the patient was in a state of coma; he had no fixed rule about emptying the uterus.

Dr. Strong said that if the patient moved when touched, he would use ether; and he believed in emptying the uterus immediately.

Dr. Reynolds spoke of the great value of ether in eclampsia and said it was his firm conviction that convulsions would not occur if all restlessness were quieted by the judicious use of the anæsthetic; he would therefore secure to the woman peace and tranquility, using only a small amount of ether when the patient was quiet, but continuing its use for hours, if necessary, even when the patient was comatose. In reply to a question by Dr. Brown, he said he would use ether nothwithstanding the uræmic condition, until it was found that its use was harmful under such circumstances. Regarding the propriety of emptying the uterus, Dr. Reynolds said that when a second or third convulsion has occurred the time for waiting has passed and the child has to be disregarded; even if viable there is little hope for the child after several convulsions; he was therefore in favor of emptying the uterus at this juncture, whatever might be the time of pregnancy.

Dr. C. E. Stedman, in reply to a question by Dr. E. P. Gerry regarding the value of the subcutaneous use of morphia in eclampsia, said that the morphia treatment was recommended by Dr. G. W. Gay, and he had himself used it with success.

Dr. W. Goss was reminded by the case reported, of a fatal case occurring under his own observation in which excessive epigastric pain was the chief prodromal symptom; he had reported this case to the Boston Society for Medical Improvement.

The Micrococcus of Vaginal Diphtheria.

Dr. H. C. Ernst, by invitation, showed a culture upon "agar-agar," microscopic preparations of a micrococcus obtained by the courtesy of Dr. W. L. Richardson, from a case of diphtheritic vaginitis at the Boston Lying-in Hospital.

The Obstetric Gazette and Lancet and Clinic to one address, one year, for $5.

AMERICAN GYNÆCOLOGICAL SOCIETY.

Tenth Annual Meeting, held at Washington, Tuesday, Wednesday and Thursday, September 22, 23 and 24, 1885.

The President, Dr. William T. Howard, of Baltimore, in the Chair.

TUESDAY'S PROCEEDINGS.

The Address of Welcome.

Was delivered by Dr. Samuel C. Busey, of Washington, who said:

Mr. President and Fellows:—I offer you the greetings of fellowship and bid you welcome as the guests of the Washington Obstetrical and Gynecological Society. Your acceptance of the invitation to hold your tenth annual meeting in this city conferred a distinguished honor upon our young Society. On the .roster of fellowship the names ef Atlee, Buckingham, Peaslee, Sims, Trask, Wallace and White are marked with the asterisk of death. Then here, at the nation's capital on this auspicious occasion, in the unity of a common purpose, let us join with you in that faith and devotion to duty which have been crowned with such marvelous success and rewards. You must lead; we will follow, and when you have completed the labors of the present meeting, and the new and renewed friendships are interrupted by your return to the scenes of your daily work, if our gratitude as pupils should be the measure of your pleasure as instructors, your second advent will not await the expiration of another decade.

The Natural Hygiene of Childbearing Life.

Dr. Busey of Washington read a paper with this title. The hygiene of pregnancy, he said, related to the preservation of the health of the woman during the period intervening between conception and the commencement of labor. The processes of transformation, development and growth which took place were physiological, but were nevertheless terminated with more or less violence and injury to both mother and child. The unavoidable mortality was, however, small. The processes of waste and repair, of growth and development, of organization and construction were next considered. There was no border line of health. We could not define where the physiological ended and the pathological began. The childbearing period began with puberty and ended with the expiration of the years of maturity. Fertility increased from the commencement of the childbearing period until the climax was reached, and then declined to its extinction. The age of greatest safety of pregnancy coincided with the age of greatest fecundity. Beyond and under, the mortality increased with the increase and diminuition of age, but the rate was higher with the increase beyond than with the diminution below the age of maximum safety or least mortality. The age of nubility should correspond with the age of maximum fecundity, maximum fertility and

least mortality. Puberty and nubility were not simultaneous. Too early pregnancies were to be deprecated. Nature presented the fifth quinquiniad as the period during which the laws of fecundity, nubility and survivial found their natural complement in relatively the highest perfection. First pregnancies were the most dangerous, and the danger, was increased by too early and too late primiparity.

The importance of lactation was next discussed. The extinction of the childbearing function protected the remaining vital forces from decay, but if the seeds of disease had already been sown the change of life might increase their activity. If the age of majority for women could be advanced so as to correspond with the first year of the period of maximum fecundity, popular prejudice and love of custom would sooner or later conform fashion to the law. Precocious matrimony was to be deprecated; it was the sequel of precocious puberty. In this country, and in the higher walks of life, the ratio of precocious matrimony is on the increase — whether equally so among the middle and lower classes the speaker did not know. He concluded by saying that the principal object of his paper was to direct attention to this subject and invite discussion upon it.

DISCUSSION.

Dr. J. R. Chadwick had made some investigations in regard to the appearance of early menstruation in women of various nationalities in this country. In over four thousand cases he had found that American women menstruated earlier than women of other nationalities examined. Furthermore, American women of American parentage began to menstruate earlier than American women of foreign parentage. Scarcely enough observations in regard to the menopause had been made to justify absolute conclusions, but it had been found that the menopause was appearing later in American women. The fact that the childbearing period was increased both at the beginning and the end would indicate added vigor.

Dr. J. P. Reynolds of Boston agreed entirely with the statements made by the last speaker, and believed that the women of the upper and middle classes menstruated earlier than they did twenty-five years ago. He believed that this indicated an activity of function which would prolong menstrual life beyond the average period of cessation.

PUERPERAL DIPHTHERIA.

Dr. Henry J. Garrigues of New York read a paper on this subject. This was a disease not referred to in the majority of text books. It was one of the forms of puerperal fever, or rather one of the diseases included under that term. It was distinguished by the appearance of diphtheritic exudation somewhere in the genital tract of the puerperal woman. It was accompanied by well marked general symptoms, imperilled life, and called for active treatment. The paper was based upon twenty-seven

cases treated in hospital practice and two in private practice. The characteristic features of the disease was the diphtheritic infiltration, which was usually of a light, pearl-gray color, generally appearing in small spots and coalescing, or extending by involving new areas. The exudation was firmly adherent to and imbedded in the underlying tissue. It was most marked at the points where the canal became narrow. This might be explained by the more frequent occurrence of lacerations at these points. The posterior wall of the vagina was more commonly attacked than the anterior wall, which was probably due to the fact that it was bathed with the discharges from the uterus. The exudation might, however, appear on entirely healthy portions of mucous membrane which had not been the seat of laceration. The connective tissue of the pelvis was infiltrated with serous fluid and was sometimes the seat of ecchymoses. The skin was sometimes the seat of a dusky erythema consisting of minute spots, disappearing on pressure, and not elevated. In one case petechiæ as large as hempseed existed. These were not affected by pressure. The same patient afterwards developed erysipelas.

In five cases ending fatally autopsies were made. The uterus was much enlarged, reaching almost to the umbilicus two weeks after labor. The cervix, having been torn, might show diphtheritic patches or a thin gray film. In two cases large portions of the cervix sloughed and the vagina became gangrenous. The tissue of the uterus was friable and might be almost diffluent.

The diphtheritic exudation might affect the Fallopian tubes. In some cases the muscular tissue of the uterus was scooped out as in dissecting metritis. This occurred in four of the cases of puerperal diphtheria. In one case the mass thrown off was four inches long, two inches wide and one inch thick. These masses had a pyriform shape, their outer surface was of a gray color and their inner surface of a flesh color. They were perforated with a number of holes leading into the uterine sinuses. Under the microscope these masses were shown to consist of a smooth, muscular fibre in a more or less advanced state of fatty degeneration. The connective tissue was increased. Lesions were also found in other organs and occasionally in the joints. Difficult labors and a previous weakened condition of the patient predisposed to the condition. The real cause of the disease was, however, an infection from without. He had never been able to convince himself that the poison passed from one patient to the other, but it seemed to be in the air of the ward. When the ward had been fumigated with sulphurous acid there would not be a seriously sick patient for weeks. That the poison came from without was also shown by the fact that when the prophylactic treatment to which he would refer was adopted the disease did not develop.

The first symptom which showed a deviation from a normal course was usually the occurrence of fever, which mostly appeared from two to four

days after delivery. Sometimes there would be a chill or chilly feelings. The temperature rose gradually as a rule. It had ranged from 100° to 107° F., the average being from 102° to 104°. Anorexia, vomiting, coated tongue and diarrhœa showed disturbance of the gastro-intestinal canal. The patient complained of pain in the epigastrium and one or both groins, sometimes extending into the legs. Examination showed the uterus larger than it should be, and quite tender. Tenderness was also often found in the groins and some swelling might also be observed. The lochial discharge was often scanty and offensive, but in some cases it had been normal. Where there was expulsion of the tissues of the uterus, there had been a purulent discharge until expulsion was accomplished. The diphtheritic patch commonly appeared from three to seven days after delivery. It continued to spread for several days and usually stopped in from three to eight days after the beginning of treatment. In one case the diphtheritic patches also appeared on the tongue, indicating that the disease was identical with the ordinary form of diphtheria attacking the throat. The irritation of the nervous system was shown by headache, stupor and delirium. There was alteration of the renal secretion and sometimes painful micturition. Three patients had albuminuria. In two cases jaundice bore testimony to the perverted condition of the blood. The sweet breath and profuse sweat of septicæmia were observed twice. One patient developed painful arthritis of the elbow joint. When the diphtheritic process was arrested the patients recovered rapidly. There was scarcely any difficulty in the diagnosis. When injections of bichloride of mercury were employed they caused a yellow discoloration of abraded surfaces. This was strictly limited to the abraded surface, and was unaccompanied by general symptoms. When the chloride of zinc was applied to the affected surface in the treatment of the disease, a slough was caused, having the color of the deposit, and the physician was sometimes at a loss to determine whether or not the disease was spreading. The point was decided by noting where the application was made and by observing the edge of the deposit. The diphtheritic deposit had a scalloped outline, while the outline of the slough from cauterization was smooth. As to prognosis, 4 out of 29 women died, giving a mortality of 17·2 per cent. Another might have have survived, for she lived 32 days and died from rupture of the uterus, which had been thinned by sloughing, while an assistant was giving an intra-uterine injection. The *post mortem* showed the walls of the uterus to be extremely thin. The duration of cases ending in recovery was usually about two weeks. In cases in which a portion of the uterus was scooped out, the organ was left in a weakened condition, which in future pregnancies might predispose to rupture. In the way of prophylaxis it was recommended to limit vaginal examinations during labor as much as possible. The finger or hand should not be in-

troduced into the uterus unless absolutely necessary. Delivery should be so accomplished as to avoid as much as possible wounding of the genital canal. Instruments should be used with great care. The most important element in prophylaxis was the use of bichloride of mercury as an antiseptic. Everything coming in contact with the woman should be washed in a solution of corrosive sublimate, 1 in 2,000. After this treatment was introduced only one case appeared in six months, and that was due to carelessness of a resident, who delivered a woman immediately after removing a macerated fetus from another woman. After the disease appears, treatment must be energetic. The only treatment which had given him satisfaction was that with chloride of zinc. The affected parts were touched with a solution of equal parts of chloride of zinc and distilled water. This was rather painful, and an anæsthetic might be used. A warm solution of corrosive sublimate, 1 in 2000 was used where this was required, and subsequently a suppository of fifteen grains of iodoform was introduced. If this was done the process need not be repeated more than once in 24 hours. The vagina wss to be douched every three hours. The parts should be examined every day, and if the process were not arrested, the application of chloride of zinc was to be repeated. If the disease was limited to the vagina and vulva, the intra-uterine treatment was omitted.

Ergot was also given for the purpose of causing contraction of the uterus. Morphine, quinine and digitalis were used as indicated. High temperature was combatted by sponge-bathing, salicylic acid, and, if necessary, the rubber coil. Carbolic acid was also given sometimes combined with compound tincture of iodine. If the temperature was not very high, warm poultices were preferred. Where there was diarrhœa warm poultices were also considered preferable.

Samples of the occlusion bandage to be used after labor were exhibited. They consisted of a pad of absorbent cotton wet with corrosive sublimate solution, over this a piece of oiled muslin or gutta percha tissue, and over all another piece of absorbent cotton, and a piece of muslin or flannel to attach it to the binder.

Dr. W. T. Lusk, of New York had treated ten years ago one hundred and fifty cases of this affection, with twenty-eight deaths. The epidemic could be traced to a woman brought into the hospital after a long labor. She was suffering at the time from a syphilitic ulcer of the vulva, which was excessively inflamed. The child was extracted with forceps, and the inflamed perineum was torn. Soon after this the diphtheritic deposit appeared and the whole ward was infected. The first cases were the result of transference from the patient, for the question of contagion was not then recognized as it is now. After a time great care was taken to avoid every possible source of contact, but the disease continued, and could only be explained on the supposition that the air of the ward was filled

with germs. In the first cases, treatment consisted in the application of equal parts of solution of persulphate of iron and compound tincture of iodine. The disease usually began with a certain amount of mildness, and gradually became more severe. Of the first twelve patients only two died, while in the second set only two recovered. In the progress of the epidemic the whole system seemed to be affected, even before the advent of labor. Since the adoption of corrosive sublimate injections he had not seen a case of puerperal diphtheria. Neither had he had a death from fever, nor any cases of fever, even the old-fashioned milk-fever being absent.

Dr. H. P. C. Wilson, of Baltimore, was averse to the use of bandages of any kind after delivery, preferring to have the napkins placed under the woman so as not to obstruct the free flow of the discharge, and to use frequent washing of the vagina with antiseptic solutions

Dr. W. L. Richardson, of Boston, had treated many cases of puerperal diphtheria with ill success, until the appearance of Dr. Garrigues's paper. After the use of the pad and the corrosive sublimate solution for the hands of the attendants and nurses was begun, the hospital had been almost entirely free from the disease. There had been no deaths since these measures were adopted.

Dr. John Byrne, of Brooklyn, asked as to the frequency of cicatricial distortions of the vagina after diphtheria, and related an interesting case of that sort.

Dr. Garrigues thought the indorsement of Dr. Lusk and Dr. Richardson would be sufficient to induce others to try occlusion pads. During the year preceding the introduction of the new method of treatment the mortality was seven per cent. During the next year, with the new method of treatment, the mortality was one and a half per cent. During the second year it was less than three fourths of one per cent. In the institutions in which these observations were made there were many disturbing elements, one of the most important being its connection with a large general hospital. In this new method of treatment the antiseptics were applied only to the outside in normal cases. Only in abnormal cases were vaginal and intra-uterine injections employed. He had only seen two of the women subsequent to recovery. In one there were great shortening and narrowing, but during pregnancy shortening took place, and labor was easy. The second woman was pregnant and the vagina appeared in good condition.

Four Cases of Oophorectomy, with Remarks.

Dr. Joseph Taber Johnson, of Washington, read a paper with this title.

Case I.—Miss M. had suffered severely from oöphoritis and menstrual epilepsy. She was 29 years of age and had suffered for 14 years. There was constant pain in both ovaries, but most of the suffering was on the

left side. For two weeks out of every month she was under the care of an attendant, her education had been neglected, and she was in a most deplorable condition. She had been under the care of the most skillful physicians, and almost everything had been tried. Oöphorectomy was therefore decided upon and performed August 17, 1882. Both ovaries and one Fallopian tube were removed. For several months she had no periods and no spasms. Gradually her menses returned and with them the convulsions in milder form. She now menstruates more regularly than before the operation.

CASE II.—Miss W., aged 21, took a severe cold at the monthly period five years before coming under observation. Since then she had suffered from chronic oöphoritis. She also had leucorrhœa and a displaced uterus, for which she was treated without material benefit. The speaker treated her for three months without benefit, and then removed the ovaries. She made a rapid recovery and has since been free from pain.

CASE III.—Miss S., aged 54, had been a great sufferer from dysmenorrhea and reflex symptoms. She suffered burning pain in the abdomen and head for ten days preceding menstruation. For several months there had been no flow, but the distressing symptoms continued. Both ovaries and tubes were removed. She made a rapid recovery, and continued healthy.

CASE IV.—Mrs. ——, aged 40, the mother of three children, had suffered pain in the region of the left ovary for 30 years. She had a lacerated cervix and perineum, which had been restored without improving her symptoms. She had been under treatment for ten years, and was practically bed-ridden for three weeks out of every month. She wished to have the ovaries removed, but the author advised her to wait five years longer until the menopause, which would accomplish the same result. She, however, insisted on the operation, and he performed it last February. She did well for three days, when vomiting set in, and she died exhausted on the sixth day.

The speaker then referred to the great importance of an early diagnosis in such cases, in order that the operation might be performed before numerous adhesions had taken place, and before the general system had become so depressed, referring to the statistics of various operators in confirmation of his statements. He thought that many patients who were now lost from prolonged operations on account of numerous adhesions might be saved if there were means by which an early diagnosis could be made.

Dr. R. S. Sutton, of Pittsburg, thought everybody knew that a woman with cystic tumor of the ovary was doomed to death if the tumor was not removed. But when she was suffering with some disease of the ovary which did not give tangible evidence of its presence, the surgeon often had difficulty in deciding as to the question of operation. Was the wo-

man to be allowed to go on suffering because evidence of disease that would justify an operation could not be obtained? It was better to give the woman the benefit of the doubt, and open the abdomen and examine the organs. He did not think anyone could tell the exact condition of the ovaries before opening the abdomen. It had now come to be the practice in obscure conditions for which no explanation could be found and in which it was probable the ovaries or tubes were at fault, to make an exploratory operation. As a rule, exploratory operations were safe. He had yet to open an abdomen and fail to find disease of the ovaries or tubes.

Dr. W. H. Baker, of Boston, feared there was great danger of the pendulum swinging too far and the operation being performed too frequently. He would not discourage the operation in properly selected cases. Greater skill was shown in curing these cases without removal of the organs. A better understanding as to when the operation should be performed and when not, would be arrived at by studying the organ itself very carefully in those cases in which it has been removed. In all reports of the operation there should be an accompanying report of the microscopical examination. The matter of early diagnosis had been referred to. It was of great importance. The ovaries and tubes were not the easiest organs to examine. Even where the ovaries were adherent to surrounding tissues it was often extremely difficult to determine this fact, and an exploratory operation might be the only way of determining it. Where an exploratory incision had been made, the organs found healthy so far as their gross appearance was concerned, he insisted that they should be put back and the abdomen closed, even if the women suffered excruciating pain with menstruation.

Dr. T. A. Emmet, of New York, said that he was not an advocate of the operation, and he thought that more harm than good had been done by its performance. There were cases where it must be done. Where there was salpingitis with the tubes filled with pus, the operation was certainly indicated. That it should be done, as it frequently was, for the relief of so many symptoms was a reproach on the profession. He did not advocate the opening of the abdomen for the purpose of making a diagnosis. If the diagnosis could not be made beforehand, he did not think it justifiable to run the risk of the abdomen. For three years he had been looking for cases in which he considered the operation indicated, and had seen but two such cases. One was a typical case in which there had been several attacks of peritonitis following gonorrhœa. Both tubes were as large as the wrist, and the history indicated the existence of pus. An operation was urged but the patient refused. For five months there was no improvement. The treatment consisted of hot-water injections, keeping the bowels regular, daily applications of iodine, and attention to the general health. After several months the tubes began to

diminish in size, and in the course of a year the accumulation had entirely disappeared and she left the hospital apparently a well woman. The second case was similar. The patient also refused an operation. She was now no worse, and in some respects better, than she was some years ago.

Dr. Lusk thought great caution must be exercised in the performance of this operation. He did not condemn it, and had himself operated in four cases in which there was distinct evidence of disease of the tube, with good success.

Dr. E. W. Jenks, of Detroit, had seen several cases in which the operation had been performed without benefit. Where the ovaries and tubes were diseased there could be no question as to the propriety of its performance. In many of the cases of so-called hystero-epilepsy, which were often nothing more than hysteria, he considered the removal of the ovaries a positive wrong. The exploratory was not free from danger.

Dr. T. A. Reamy, of Cincinnati, said that a woman had been sent to him with dysmenorrhœa and hysterical symptoms, with the request that he should remove the ovaries. Five months' treatment of the cavity of the uterus, with change in the patient's surroundings and general treatment, resulted in entire recovery. He had seen several other striking cases. It was the exception to find the ovary healthy in women after the age of forty.

Dr. Emmet thought that the operation should never be done for dysmenorrhœa. He considered dysmenorrhœa a neuralgic condition, the result of anæmia. When dysmenorrhœa was relieved by the operation it was because the general nutrition was improved by the removal of the ovaries.

Dr. Sutton agreed with Dr. Baker that where, in an exploratory operation, the ovaries and tubes were found to be healthy, they should not be removed.

Dr. Mann said that, although, Dr. Emmet had stated, dysmenorrhœa was a neuralgic condition, he thought that that condition might become so firmly established that it could not be relieved without taking out the organ affected with the neuralgia. In two such cases he had thought the operation indicated. In one the patient was free from pain only three days of each month. He advised the operation, which was performed by Dr. Clark, of Niagara Falls. The patient completely recovered. The second case was his own. The women had suffered for a number of years with excruciating pain. The ovaries were enlarged and tender. The whole abdomen was tender. The ovaries were removed and the patient entirely recovered her health. He could not admit that there were no cases of ovarian dysmenorrhœa which could be relieved by the operation, but they were rare.

Dr. Johnson had not recommended the operation except under well-marked indications. He agreed with those who feared that the opera-

tion might be performed oftener than necessary. Its use in nervous and neuralgic conditions was not always so beneficial as in some other conditions, such as myoma of the uterus, for example.

WEDNESDAY'S PROCEEDINGS.

The President read his annual address. It was entitled

TWO RARE CASES IN ABDOMINAL SURGERY.

CASE I. S. H., a negress, aged twenty-four years, married, presented herself at the dispensary of the University of Maryland, April 20, 1882. She was seen by the clinical assistant and the following notes were made: Menstruation appeared at the age of fourteen, and had been regular and normal. She was the mother of five children, the youngest of which was two months old. She had never had a miscarriage. Some days after delivery she noticed an enlargement in the lower portion of the abdomen, which gradually extended in the middle line until it reached the umbilicus, and was attended with bearing-down pains and frequent micturition. On examination, fluctuation was found well marked all over the abdomen, with decided resonance about the umbilicus. There was dulness on percussion and there was bulging in both flanks. Six weeks later she returned to the dispensary, and at this time the resonance at the umbilicus had disappeared and the umbilicus projected. The author saw her for the first time two weeks after this observation was made. She was then quite sick, the temperature being 102° F., the pulse 132, and the respiration 32. Examination showed the presence of fluid in the pleural sac. There were also some crackling rales. The abdomen was as large as at the seventh month of pregnancy and was remarkably protuberant in the center. There was complete dulness over the entire abdomen, not changed by change of position. There was no evidence of a solid tumor, but it had every appearance of a simple unilocular cyst. Vaginal examination showed the uterus well in front of the tumor, and the sound gave a measurement of two inches and three-quarters. The question which arose was as to the nature of this tumor. Was it ovarian? The extreme infrequency of ovarian tumors in the negro race was against this view. The rapid growth of the tumor was also opposed to it. The next affection considered was fibro-cystic tumor of the uterus. This was exceedingly rare. The speaker had seen but one such case in the negro. In that case the cyst was filled with pus. The patient was operated upon with a fatal result. Such tumors were rare before the age of thirty-five. They usually developed slowly. There was no menstrual disturbance in this case. For these reasons, fibro-cystic tumor was excluded. Was it a parovarian cyst? They usually developed even more slowly than ovarian cysts. They were usually flaccid, contained a thin liquid, were comparatively rare, and did not affect the general health. This was therefore excluded. It was certainly not a case of simple ascites, but was it a case of encysted dropsy of the peritoneum, so-called, result-

ing from simple peritonitis? This was an extremely rare affection, and in the early stages there were symptoms of constitutional disturbance; the abdomen was not prominent and often it was flaccid. Encysted dropsy was excluded. Finally, on June 20th, he aspirated the cyst under antiseptic precautions. The fluid which escaped was of a light straw-color and coagulated as speedily as blood. After aspiration, large masses were readily felt through the abdominal wall. The character of the fluid corresponded with that which was said to characterize fibro-cystic tumors of the uterus. The speaker had, however, seen other cases which showed that the character of the fluid was not pathognomonic. In one case of abdominal tumor, fluid was removed which did not coagulate even after being kept for many days. The abdomen was subsequently opened and a fibro-cystic tumor found. In a case of supposed ascites in a man, aspiration was performed and the fluid removed coagulated quite rapidly.

After the cyst was aspirated the patient did well for three days, when acute peritonitis supervened and she died on the seventh day. At the autopsy a mass as large as a child's head was found in the abdomen. This consisted of omentum, the transverse colon, and small intestine bound together by inflammatory exudation. The inflamed peritoneum was invaded everywhere with miliary tubercles. There was no ovarian or uterine disease. There was some tubercular ulceration of the small intestine; the other abdominal organs were not affected. The pleura was also invaded with scattered miliary tubercles. In both lungs there were some tubercles.

This, then, was a case of encysted tubercular peritonitis simulating ovarian or parovarian cyst. The failure to recognize the true condition was ascribed to want of attention to the previous history of the case and the non-recognition of the fact that there had been free fluid in the peritoneal cavity at the first visit.

The speaker then referred to the few similar cases which had been reported. In these cases the disease had appeared as a rule under the age of twenty-five years. It had progressed rapidly, the length of time varying from six weeks to eight months.

Case II. F. R., aged twenty-four, was admitted to the hospital in July, 1883. She professed to belong to the colored race, but looked much like a white woman. She had been married a year, but had never been pregnant. There was no evidence of uterine disease. The abdomen was much enlarged, measuring forty-seven inches just below the umbilicus. Vaginal examination showed the uterus pushed forward by a sac containing fluid. There was apparently an immense unilocular sac. This had been first noticed seven or eight years before. The increase in size had been gradual and unaccompanied with pain. As to diagnosis, ascites was dismissed both on account of the physical signs

and the absence of any cause to account for such a condition. The length of time which the affection had lasted was against its ovarian origin. There were, however, exceptional cases in which an ovarian tumor might be present for a number of years, even as many as twenty-four, without requiring operation. The age of the patient, the length of time which the cyst had been present, the marked fluctuation, and the flaccid nature of the tumor, were in favor of a parovarian cyst. There was one point against this diagnosis, and that was that, although the cyst was flaccid, it could not be compressed below the umbilicus. Fibro-cystic tumor was readily excluded. The history of the case was against the existence of encysted peritonitis. The balance of evidence seemed to be in favor of an ovarian or parovarian cyst.

On July 13th the operation was performed. It was done largely with the view of exploration. The peritoneum was found much thickened and closely adherent to the sac. With difficulty the adhesions were separated for a short distance, and the cyst presented the appearance of an ovarian cyst. A trocar was introduced and forty pounds of a greenish, viscid fluid were removed. An endeavor was made to enucleate the cyst, but the adhesions were so extensive that this could not be accomplished. The cyst was then incised to the extent of the abdominal opening, and, on looking into it, it appeared to occupy the whole abdominal cavity, stretching tightly over the spinal column. A small portion of the wall of the cyst was removed, a drainage-tube introduced, and the opening closed with stitches. Peritonitis ensued and the patient died. A post-mortem was made, but, owing to the speaker's unavoidable absence, was not sufficiently full to throw any more light upon the case than had been obtained at the operation. The nature of the cyst therefore remained unsettled.

Dr. T. A. Emmet, of New York, said that the older he got, and the more experience he had, the more uncertain he was about diagnosis. When a woman had an abdominal tumor he favored opening the abdomen to make the diagnosis, because she had something which must come out. As to rapidity of development, it could not be depended upon. He had seen parovarian cysts develop in six weeks; he had also seen cases which had lasted twenty-three years. About two years ago he saw a case in which he could not make a diagnosis. The abdomen was opened and just such a cavity as had been described was found. It seemed as though a cyst had at some time ruptured and its contents had become encysted. The cavity was left open and frequently washed out. In six weeks its size had greatly diminished. Unfortunately, the patient died at this time from strangulation of the small intestine.

Dr. Wm. Goodell, of Philadelphia, said that he had removed tumors the nature of which he did not know to this day. In one case he worked for forty-five minutes before finding out what the tumor was. It turned

out to be two ovarian tumors which had coalesced, including the uterus between them. He felt more and more the necessity of performing the exploratory operation, for without this it was impossible to make a correct diagnosis in many cases. To illustrate the difficulties of diagnosis, he reported a case seen some time ago. A lady presented herself with a solid tumor of the abdomen. There were also metrorrhagia and menorrhagia. He diagnosticated fibroid tumor of the uterus, but the growth was so mobile as to suggest the possibility of a fibroid tumor of the ovary, and it was so noted at the time. An operation was not recommended. The lady went North, and her sufferings became so great that she consulted a distinguished gynecologist, desiring an operation. The operation was performed, and a large fibroid of the ovary removed.

Dr. T. A. Reamy, of Cincinnati, wished to put on record another case in which a fatal result followed aspiration in tubercular peritonitis. The patient was a man, but the enlargement presented all the characteristics of an ovarian cyst. Death took place the second day after the removal of the fluid.

The President thought that in the majority of cases a correct diagnosis could be made. The fact that he was able in these cases to eliminate so many of the ordinary conditions which gave rise to tumors showed that we had the means of making the diagnosis generally. The object of the paper was to give an accurate account of these cases in order that it might assist others in cases of obscure abdominal tumors.

The Care of the Perineum during Labor.

Dr. Reamy read a paper with this title. He referred to the various opinions which had been expressed upon this subject. There was a general agreement as to the importance of preserving the perineum. In certain cases, however, from anatomical and pathological conditions, laceration was almost inevitable. The author then spoke of the various methods which had been proposed, dividing them into two classes—those which aimed to support the perineum and those which were used with the object of retarding the head. There was one class of authors, numerically small, who believed that the perineum should be let alone.

The method about to be described he had adopted several years ago, and it had given him much satisfaction. He was persuaded that he had saved many perinea by its use. It was recommended for primiparæ and others where the structures were greatly imperilled. During the early part of the second stage the patient was allowed to assume any position she preferred, but when the head began to distend the perineum she was placed across the bed with her legs in the lithotomy position, with the exception that the knees were kept close together. This was important. The limbs were held in that position by two assistants. A piece of muslin or a towel, ten inches wide and forty or fifty inches long, was carried around the buttocks of the patient and over the hemisphere produced by

the bulging perineum, with the upper edge on a level with the fourchette and the ends were given to the assistants, who were instructed to make traction during the pains in the manner that the accoucheur might direct. The bandage must be applied smoothly. The force might be exerted in any required direction. Care must be taken, however, that the pressure was evenly distributed and that the assistants did not simply pull on the middle or posterior part of the bandage while the anterior portion was left lax.

In order to show that this procedure was based on good anatomical grounds, the speaker next referred to the anatomy of the perineum, illustrating his remarks with diagrams. According to the old descriptions of the anatomy of this region, it was considered that the muscular fibres decussated in the part situated between the vagina and the rectum. Recent observations showed that this was not the case, but that the fibres simply met, and a laceration of the perinæum divided no muscular fibres transversely, with the exception of those of the transversi perinæi. The fibres were simply separated. When the sphincter ani was divided, its fibres were of course divided transversely. The perinæum was prevented from laceration by the protection afforded by the tissue below and the integument. The bandage used in the way described afforded a supplementary perineum as it were. By keeping the limbs in position indicated we enabled nature to supply tissue for the relaxation of the perinæum. When the perinæum bulged the sulci at the sides disappeared, and the perinæum with the advancing head formed almost a hemisphere. The towel was in contact with every part of this hemisphere. The advance of the head might be retarded by making traction on the towel. Where it was accessible a narrow bed might be used with advantage, the assistants taking their positions near the head of the patient. The use of this bandage avoided any tendency to excite expulsive efforts from reflex irritation of the perinæum as was sometimes seen where the fingers were used. It was comfortable to the patient and did not cause more exposure than other methods. The bandage might be kept on until the shoulders were born, thus avoiding rupture from this cause. In order that this method should be successful, it was important that every detail should be carried out with pains-taking care. Should a rupture occur, the immediate operation should be resorted to.

Dr. M. D. Mann, of Buffalo, said that the method seemed a good one in a certain proportion of cases, but he had seen some cases where it would have been of no avail. The worst ruptures occurred in cases where, at the acme of the final expulsive pain, the woman had torn herself from the accoucheur. In such cases the use of chloroform would of course obviate the difficulty. Another objection to the method was that it required more assistance than could always be secured.

Dr. J. R. Chadwick, of Boston, thought the term "supporting the perinæum" a misnomer. What was meant was retardation of the child's

head until the tissues could be sufficiently stretched to permit its passage. He always insured the slow exit of the head and did not permit it to escape during a pain. The method which he employed was to have the patient on her side, and then pass one arm over the thigh. Then, by interlocking the fingers, any desired amount of pressure could be made.

Dr. Ellwood Wilson, of Philadelphia, had tried every method suggested for the support of the perinæum, with the exception of the one just described by Dr. Reamy. His usual plan was simply to instruct the woman to keep her mouth open during during a pain and pant.

Dr. Reamy, in reply to the statement by Dr. Chadwick, that supporting the perinæum was a misnomer, said that the word support meant protection or succor, and had been used in this sense. The number of assistants required had been objected to, but the importance of preventing rupture of the perinæum in the first labor was so great that, even if two or three skilled assistants were required they should be employed. With this method the patient could not get away. An objection referred to by Dr. Chadwick was that the pressure was not made over the perinæum, but over the head, and extension might be produced, causing the head to come into a bad relation to the axis of the outlet. In cases in which the head had been permitted to remain pressing on the perinæum for some time, the tissues were in a state of beginning necrosis and exceedingly friable. Even in such a case the use of a towel or bandage lessened the perils of the perinæum, and would often be saved where otherwise it would have been torn. It could not be supported with the hand under such circumstances. If it was desired, the forceps might be applied with the bandage in position.

A Case of Cæsarean Section.

Dr. Edward W. Jenks, of Detroit, described the following case, which he had seen in consultation. The patient, aged twenty-seven, had given birth to one child five years previously without special difficulty. Two years later she received a fracture of the ilium from a building falling on her. She was taken in labor at three o'clock in the morning. The physician in attendance, finding some difficulty, tried to apply the forceps. He got one blade on without difficulty, but could not, after several trials, introduce the second blade. He sent for assistance, and the attempt to apply the forceps was again made without success. The cause of difficulty was a projecting shelf of bone at the seat of fracture. Another physician was called in and the forceps was again tried. It was then decided to perform craniotomy, which was done, but still the head could not be made to descend. Dr. Jenks was then sent for. He tried to apply the forceps to make sure that it could not be applied, and, failing, tried the cephalotribe with no better success. It was then decided to make abdominal section. This was performed at two o'clock that night, twenty-four hours after labor began. The woman appeared to be in good

condition. The placenta was found attached directly under the incision and there was alarming hemorrhage, which, however, was quickly checked by the rapid extraction of the fœtus. The edges of the uterine incision were brought together by silk sutures and the abominal wound was closed. The patient did well until three days after the operation, when she suddenly died. It was subsequently learned that the nurse had, in disobediance to orders, temporarily left the room, and that in her absence the patient got out of bed. She complained of feeling something give way, experienced severe pain, and died in a few hours.

Dr. A. J. C. Skene, of Brooklyn, remarked that in such cases the chances of the patient were lessened by the undue efforts at delivery with the forceps. He thought that this would have been a good case for the performance of laparo-elytrotomy. It was impossible to sacrifice the child by that operation if it was performed in time. He could hardly imagine any case where craniotomy should be performed, except possibly where the head was so engaged in a small inferior strait that it could be extracted in no other way. Even then he was not certain that the Cæsarean section would not be the best operation.

The Use of Tarnier's Forceps.

Dr. Elhwood Wilson read a paper on this subject in 1881. He had offered a number of objections to the use of the forceps. His objections had been based on theoretical grounds. The object of the present communication was to report nine cases in which he had used the forceps with decided advantage to the patient. He had therefore modified his views as before expressed. A detailed account of the nine cases in which the forceps had been used was then given. The instrument used was then showed. The instrument used had been Dr. Howard's modification of Tarnier's forceps.

Dr. Mann had used the Tarnier forceps for the past two years in a number of cases with, in the main, satisfactory results. In one case of deformed pelvis in which the Tarnier forceps was applied, the child was injured by it. The outer edge of one orbit had been crushed in, destroying the eye. The child was living at the time of birth, but subsequently died.

The President said that, so far as he knew, he was the first to use the Tarnier forceps successfully in America. In cases of occipito-posterior positions, the application of other forceps interfered with the rotation of the head, but with the Tarnier forceps the head was free to rotate.

THURSDAY'S PROCEEDINGS.

A Modification of Emmet's Cervix Operation in Certain Cases, with a Case.

Dr. R. Stansbury Sutton, of Pittsburgh, read a paper in which he stated that, while the operation was original so far as he was concerned, he did

not profess to be the only one who had performed it. Cicatricial tissue was found to a greater or less extent in every case of lacerated cervix which had lasted for any length of time. This was especially apt to be the case where nitrate of silver had been used in the treatment. The hardened tissue might be present in both lips, or it might be limited to one lip. The patient whose case was reported was operated on June 6, 1885. She was the mother of several children. There was a double maceration of the cervix. The tissue of the anterior lip was hardened and hypertrophied, and the lip was convex from side to side and also from before backward, so that by the ordinary method of operation correct coaptation could not be effected. The tissue of the anterior lip was as hard as cartilage. Ordinary denudation of the posterior lip was sufficient, and this was made, leaving the strip of mucous membrane somewhat wider than usual. The cicatricial mass involving the anterior lip was removed from border to border, completely denuding this portion of the cervix. The parts were then brought together in the usual way, and the result was excellent. The cervical canal readily admitted a sound, and the woman menstruated without difficulty. The speaker thought that there were cases in which nothing short of the complete removal of the cicatricial tissue would be sufficient.

Dr. Goodell had resorted to this device on more than one occasion, and also to another plan on a few occasions. That was to outline the strip of mucous membrane to be left, and to dissect it from the tissues below, leaving it united at its base. The indurated tissue had then been removed and the flaps brought together. The result had been good.

Dr. Skene remarked that this was not cicatricial tissue; it was a true sclerosis—a hyperplastic, indurated tissue. This was, however, simply a question as to name. Much could be done to get rid of this tissue by preparatory treatment. But this often required too much time, and then such an operation as that proposed by Dr. Sutton came in. His plan had been to do a preliminary operation, consisting in removing a transverse wedge-shaped piece from one or both lips of the cervix, as the case might require, and then bringing the surfaces together with silk stitches. After the first day the patient could go about, and the sutures were removed in the course of a week or ten days. After the size of the cervix was reduced the ordinary operation was performed. He had done both operations at one sitting, but preferred to do them separately. One objection to the method of Dr. Sutton was that it left cicatricial tissue.

Dr. Geo. J. Engelmann, of St. Louis, said that in old and severe cases it was impossible to retain the strip of mucous membrane. He therefore removed it. He had done this on both lips, and on some occasions had complete union, but the passage of a probe served to keep a canal open. For the last few years he had paid no attention whatsoever to this central strip. To prevent union he inserted a single piece of the carbol-

ized-silk thread which was used in closing the opening. A probe passed a few times after the removal of the sutures would dilate the canal. The result of this operation had been good. The union, the involution, and the restoration of the health of the patient had been perfect. The operation had been done only in severe cases, and, so far as he knew, none of these patients had conceived.

Dr. Mann had tried the method described by Dr. Sutton. In only one case had it been necessary to denude both surfaces. To insure a patulous canal he introduced a piece of small drainage-tube. The patient did well.

Dr. W. H. Baker of Boston, thought the retention of the mucous membrane of importance. The method of Dr. Sutton, by leaving cicatricial tissue on one side of the canal, would tend to make the canal tortuous. As a rule, if the patient was properly prepared, it would not be necessary to remove this hypertrophied tissue. If this was not done, Emmets operation could still be performed in the way described by Dr. Skene. He preferred to do both operations at the same time. It was then not necessary to introduce a suture to bring the transverse incision together. Great care should be exercised in the introduction of substances between the two flaps.

The President remarked that a few weeks before the death of Dr. Sims he had seen Dr. Harry Sims perform this operation in the presence of his father. He inserted a glass tube that fitted so loosely that it had to be retained with a plug of cotton.

Dr. Skene thought that if the denudation was practiced on both sides stenosis would certainly follow.

Inflammation of the Parotid Glands Following Operations on the Female Genital Organs.

Dr. Goodell read a paper with this title. He referred first to the close relation existing between the salivary organs and genital organs of the adult, as shown in mumps and other conditions. Parotid bubo seemed particulary apt to follow ovariotomy where septicæmia had taken place. He had seen parotid bubo once in 153 ovariotomies. This was in a greatly emaciated woman, from whom a tumor weighing 80 pounds had been removed. The patient had been twice tapped; once six weeks before the operation. The second tapping was followed by septic poison, and the operation was performed as a last resort. The patient did well until the ninth day, when the left parotid gland began to swell. It suppurated and was opened. The patient finally died on the twenty-second day after the operation.

There was a transference of irritation to the parotid glands in which there was no evidence of septic poisoning. Of this the author had seen three instances; twice after ovariotomy and once after oöphorectomy. In these cases the parotid complication did not influence the progress of

the case. Not one of these ended fatally. He regarded the affection of the glands as sympathetic and not symptomatic. Within a short time he had operated on a lacerated cervix. The operation was followed by free hæmorrhage, and in the second week the parotid glands began to swell. This was succeeded by hysterical trismus, which lasted for sometime. The patient recovered.

Dr. Sutton, out of twelve ovariotomies, had lost one patient, and she died with the complication referred to in the paper. The case did well until convalescence was reached, when one parotid gland began to swell. This was followed by the swelling of the other gland. The temperature varied one or two degrees from the normal. There was slight diarrhœa, but no tympany, and no soreness. A number of rose-colored spots were found about the second week over the abdomen and arm. In the third week she became much worse. The glands diminished in size, but the temperature ran up and she died. He considered the case as septicæmic. Others considered it a well marked instance of typhoid fever.

Dr. J. Taber Johnson, of Washington, had seen this complication in one case of ovariotomy, the patient dying on the sixth day.

Dr. Mann referred to three cases he had seen. The first was a case of ovariotomy. There were distinct symptoms of septicæmia, and the patient died before the glands suppurrated. The second case was one in which he had removed all the uterus above the internal os, and also the ovaries. At the end of the first week one gland became swollen. There was little fever. The patient made a good recovery. Third case was that of a boy who had received a penetrating wound of the abdomen. Enlargement of the glands followed, but he made a good recovery.

Dr. Emmet added two cases. Once the condition followed an operation for lacerated cervix, the patient recovering. Once it followed an operation on a small vesico-vaginal fistula, the patient dying.

Dr. Baker had seen the complication follow Tait's operation, but the patient recovered.

Dr. Reamy had had two cases, one after Tait's operation. The patient died the seventh day after the operation. The second was a case of supra-vaginal hysterectomy in which the uterus and both ovaries were removed. The left gland became much enlarged, but did not suppurate. The patient recovered.

Peristalsis of the Genital Tract, and a New Theory to Explain Relaxation of the Vaginal Oulet During Labor.

Dr. James R. Chadwick, of Boston, read a paper with this title. Some time ago the speaker was called to see a primipara in labor. He found the os slightly dilated and the vaginal outlet quite rigid. Returning two hours later, he found the outlet much relaxed, although the head had not escaped from the uterus. On another occasion a woman with a bleeding fibroid tumor consulted him. The examination revaled quite a

small outlet. Ergot was given to check the bleeding. After that the outlet was found much relaxed; this had occurred coincidently with the occurrence of uterine contractions and the forcing down of the tumor. Further investigations of this subject had led him to the conclusion that there was a peristaltic action of the lower portion of the genital canal as well as of the Fallopian tubes, and that it was to this that the relaxation of the outlet was largely due.

Facial Paralysis in the Infant from the Use of the Obstetric Forceps.

Dr. Theophilus Parvin, of Philadelphia, read a paper on this subject. The following case was described: A well-proportioned woman, aged thirty years, had been in labor thirty-two hours, the first stage lasting twenty-four hours. The only difficulty appeared to be want of strength in the uterine contractions. The forceps was therefore applied and the child extracted. The following day it was observed that one side of the face was paralyzed. This was especially noticeable when the child cried. There was no evidence of bruising from the forceps. The paralysis disappeared in ten days without treatment. The literature of this affection was then summarized.

Dr. Ellwood Wilson had met with this accident a number of times. Recovery, as a rule, had occurred spontaneously.

Dr. Goodell had seen such cases, and in every instance the paralysis had been on the right side. He attributed this to the predominance of the left occipito-anterior and the right occipito-posterior position. Under such circumstances, one blade of the forceps would make pressure on the nerve.

Dr. Skene considered the differential diagnosis between facial paralysis from injury and facial paralysis from apoplexy to be of importance. Usually the diagnosis was readily made, but difficulty occurred when there was facial paralysis from injury, associated with paralysis of the arm caused by violence in delivery. He had recently seen such a case in consultation. In this case it was of great importance to complete the labor quickly, and the shoulder had been in delivery, so that there were facial paralysis and paralysis of the arm on the same side. At first there was no trace of contusion, but in a short time ecchymosis appeared and a favorable prognosis was given, which was verified.

Dr. W. R. Richardson, of Boston, said that in most of the cases he had seen the paralysis had been on the right side. It sometimes occurred where the forceps were applied to the aftercoming head.

The following papers were read by title: "The Genu-Pectoral Posture in the Prolonged Nausea and Vomiting of Pregnancy, with Cases," by Dr. H. F. Campbell, Augusta, Ga.; "A Study of an Unusual Type of Puerperal Fever," by Dr. Fordyce Barker, New York.

A resolution expressing the sympathy of the society with Dr. Albert H. Smith, of Philadelphia, in his sickness, was offered and adopted.—*The New York Medical Journal.*

TRANSACTIONS OF THE OBSTETRICAL SOCIETY OF CINCINNATI.

Meeting of Sept. 11, 1885.

Dr. J. L. Cleveland, President *pro tem.*, in the Chair.

Dr. Henry Illowy read the following paper on

Uterine Hemorrhage.

I must apologize to the Society for trespassing on their indulgence with a paper on so well worn and limited a subject; the only excuse I have to offer is that the subject has been one of great interest to me, and that attendance on such cases has at times caused me considerable worry.

I beg to premise at the outset that I exclude from consideration in this paper post partum hemorrhage and such as is attendant upon abortions.

Uterine hemorrhage, judging from my limited experience, is not of infrequent occurrence, and though I believe it is generally held that they are not attended with lethal consequences, though there is a possibility of such, it is nevertheless certain that frequently great damage is inflicted upon the patient, giving rise to chronic anæmias, diverse neurotic troubles and their consequences.

It is not, I believe, a difficult matter to differentiate between a profuse menstruation and a hemorrhage.

Whenever it is found that the blood gushes out in a full stream so as to saturate the clothes and bedding around the patient, and that coagula are formed, we may be certain that we have a case of hemorrhage to deal with that requires immediate attention.

What is the cause of these hemorrhages? It is laid down in our text books that in the majority of cases they are brought on by overwork, debilitated conditions of the general system which causing a relaxation of the normal healthy structures, promote a too abundant outflow.

It may be true that such is the case, but in the limited experience that I have had the hemorrhage could be traced to a more direct and definite cause, for these causes being removed, the hemorrhage ceased.

I. The first case of hemorrhage that I was called to attend was in 1873. The patient, about 43 years of age, had been thus troubled, according to her history, for the past twelve years. She had a very severe attack, but under the use of remedies the hemorrhage was soon controlled. I advised that she submit to an examination. She refused.

She had a second attack, and this time she really came near losing her life. It was a week before the hemorrhage, which was frightful, was thoroughly controlled, by which time she was perfectly blanched and was

greatly debilitated. I again urged an examination, but she replied, "Dr., I have been suffering in this way now for nearly twelve years. In that time many eminent practitioners have attended me, and no one ever thought there was anything else the matter with me than that my courses were too strong. They did not examine me and I do not want to be examined now." Some time after this she was seized with a hemorrhage on her way home from market, and had great difficulty in getting to her house, aud although she always kept herself well bound up, she left blood tracks nearly the whole distance. This was too much for her, and after the flow was arrested she consented to an examination. I examined her and found a large polypus extruded from the uterus. Dr. P. S. Conner removed the polypus and the lady has been free from trouble and has enjoyed excellent health since.

II. I was asked by a brother practitioner to see a case of uterine hemorrhage with him. This was the third occurrence. After the cessation of the hemorrhage, when the patient had somewhat recovered, her physician examined her and found two small polypi protruding into the vagina.

III. In 1882 I was called to attend a lady about 38 or 40 years old, suffering from uterine hemorrhage. I treated her. She had several subsequent attacks coming on at the menstrual period with great regularity. I advised that she submit to an examination. She refused. It was the same story. She had now suffered thus for the past two years and over and had had several prominent practitioners attend her during that time, and had been informed that nothing could be done except to check the hemorrhage when it occurred and wait for the climacteric period to affect a permanent cure. However the suffering entailed by the recurrence of the hemorrhage and the rapid breaking down of her general health at last induced her to submit. I made a vaginal examination and found nothing more than an induration of the posterior cervical lip. I called in Dr. Reamy, the uterus was dilated and a small tumor found hanging from the fundus of the uterus. This was removed by Dr. Reamy, and the lady has since been free of her trouble, and though she suffered long from the consequences of the great drain upon her system, she has fully recovered and is now enjoying good health.

IV. I saw a case with a colleague in which none of the approved remedies and measures proved of any avail. We could check the hemorrhage for a few hours, and then it would reappear as severe as before. I suggested that it was due either to polypus or to villious growths. If I am not mistaken, Dr. Reamy was called in. He found large villosities, curetted, and the hemorrhage ceased. The patient was between 28 and 32 years old.

V. This was a young woman about 25 years of age, very much debilitated, and suffering from a severe dyspepsia. She was seized with very

severe uterine hemorrhage. An examination revealed that it was due to a mole; this was extracted and the hemorrhage ceased.

VI. In the spring of this year I was called to see Mrs. S. She was having uterine hemorrhage. She is 42 years of age, enjoys good health, and is the mother of a large family. I treated her and the hemorrhage ceased. From neglect, however, it occurred again and it was fully two weeks before she was able to be up this time. I suggested to her the advisability of submitting to an examination. She refused for the present, assigning as a reason that she had always as long as she can remember, menstruated very profusely, having at rare intervals, at the menstrual period, regular hemorrhage for which she called in a physician. The same was the condition of her sisters — all suffering from very profuse menstruation that at times assumed the hemorrhagic character. This seemed to me to indicate an idiosyncrasy in the family like hæmophilia. This having been my first attendance I did not insist any farther.

VII. Another and last case of prolonged hemorrhage that I saw was this summer. Dr. Trush saw the case with me. An examination revealed nothing, but I believe that in this case, a young woman about 25 years of age, very much debilitated by many and severe attacks of disease, and compelled to work very hard for herself and four children, I could trace the hemorrhage to direct and brutal usage about the menstrual period on the part of a drunken husband.

Resuming, we find seven cases of hemorrhage. Causes: Polypi, 3; mole, 1; granulations, 1; hereditary tendency, 1; believed to be due to violence, but possibly owing to debilitated condition, 1.

Thus it will be seen that out of a total of seven cases FIVE are positively due to causes directly connected with the uterus; causes that required removal to cure the patient.

The one case referred to can, in accordance with the family history given, be assigned to a peculiar hereditary hemorrhagic tendency, I believe, for the lady enjoys good health and is able to take care of her large family, and does not show that debility which we find in other cases of too profuse menstruation where this is dependent upon an accidental cause.

Only one out of the seven can be ascribed to a general debilitated condition, and even in this it is a question whether the brutal violence of her drunken husband was not the main factor; the information received from her co tenants and my previous knowledge of her husband's habits lead me to believe that such was the case.

It is true that the number of cases given is too small to conclude therefrom as to all cases, but I am led to think that should the cases that come under the attention of practitioners be carefully examined a greater number will be found to be due to some direct and immediate cause, and the prominence of general prostration and debility as a factor of this condition be greatly diminished.

The history of the first and third cases certainly indicate the necessity of a thorough examination when such is possible.

The question of great importance is, what shall we do to arrest the hemorrhage? Though it may be true that there is no danger of death, still at times our patients come so near it that it is decidedly unpleasant both for them and the physician. One of my cases had a most profound fainting fit that she was with great difficulty rallied from, and when I came to the house I found a priest who had been summoned to administer the last sacrament. Others have suffered from palpitation and cardiac neuralgia, at least that form of difficulty in the cardiac region as to drive them nearly mad. One case suffered from severe cephalaliga of the migraine type, with spasmodic closure of the left eyelid, so that the patient was compelled to place a bandage over the eye. Besides this immediate suffering, the system generally suffers, and in some it is a long time before it recovers its normal equilibrium. In one of the cases here cited it was fully a year and a half before it could be said that the patient had fully recovered. She suffered for a long time from headache, a sense of pressure on top of the head, that caused her great misery.

Before the publication of Prof. Hillebrandt's paper on the use of hot water in post partum hemorrhage, I treated the class of cases here referred to in the following manner: Ice or cloths wrung out of ice water were applied to the abdomen and a mixture like the following given:

℞. Quinia sulphat. ʒss.
Acid. sulphur. dilut. ʒij.
Aq. destill ʒvi.
Syr. rub. id. ʒi.

M. Sig., one teaspoonful every two hours.

At the same time the patient was not allowed to eat anything warm. Everything was given cold. In one case this was kept up for a week. I must say that I have had good results with this quinia combination, believing as I do, and as demonstrated by Prof. Laborde, that quinia really possesses a power of promoting uterine contractions.

Since the introduction of the hot water method I have preferably used this. I give an injection of hot water, temperature about 110° F., into which I put about a scruple of powdered persulphate of iron. This generally arrests the flow for a time. I then make a plug of cotton, saturate this in glycerine into which a little of the iron powder has been mixed and introduce this well up close to the os and then put in another. I direct a pill of ergotine, gr. i., to be taken every two hours, or ten drops of Squibb's fluid extract of ergot. This treatment is kept up until the hemorrhages ceases, the injections being repeated two or three times per day.

Sometimes when ergot fails I have had good results from gallic acid, either alone or in combination with quinia. Five grains of gallic acid

every two hours, or 3 grains of the acid with 2 of quinia. An excellent formula, that I owe to Dr. Trush, is the combination of gallic acid with aromatic sulphuric acid in some suitable vehicle.

With this means I have till now succeeded in arresting the severest cases of hemorrhage. The measures resorted to for a radical cure have already been mentioned in the first portion of this paper.

DISCUSSION.

Dr. Palmer regarded the subject of uterine hemorrhage as one so broad that it would be impossible to discuss it in all its bearings this evening. It would have been better had some one feature of the subject been dwelt upon as a basis for discussion.

As the causes of uterine hemorrhage are many in number, either local or general, consequently the treatment is either local or general. No class of diseases for accuracy in diagnosis require greater acuteness in observation and more thoroughness of general medical knowledge than those attended with uterine hemorrhage. Doubtless, more cases arise from local than from constitutional causes, and mistakes in diagnosis are made in either direction, that is, local treatment is instituted when nothing short of the constitutional will succeed. The reverse is also true.

Dr. Trush said that he arose simply because his name had been mentioned in connection with one of the cases reported by the essayist. When he was called to see the case no other cause could be made out than that it was due to extreme violence on the part of the husband. The cervix was completely closed, and the speaker was not prepared to dilate the same. Nor did he consider it necessary to do this because the hemorrhage was due simply to violence. Treatment was adopted accordingly, and it had the desired effect. The speaker also considered the subject too general for discussion, unless some one part of it were taken up.

Dr. Illowy said he thought he had offered a theme for discussion. His paper bore mainly on one point, the causality. Do these cases depend more frequently on constitutional causes, or are they generally due to local ones? Was his experience as related in the paper, in which, in the whole number of cases, with one exception, the hemorrhage was due to a local cause, exceptional, or was it the same as that of other members of the Society? Having excluded from the outset post partum and hemorrhage from abortion, he believed he had very distinctly defined the limits of the discussion, and not left it as boundless as the previous speaker seemed to believe.

Dr. Jones remarked that since the essayist had explained his proposition more clearly the speaker would say: If a woman called on him to attend her, saying she had been under the care of one or two physisians, and giving the history such as represented, he should consider it his duty to make the proper examination, as it would be lost time to attempt the treatment under such circumstances as mentioned by the essayist.

The case of fibroid polypus operated on by Dr. P. S. Conner was a typical one. The speaker could not see how it was possible for anyone to overlook it, as the tumor filled the lower pelvis. Dr. Illowy did right to say that unless he could make the proper examination he would decline to treat the woman. The result proved the correctness of his first judgment. If the gentlemen who had charge of the case previously had insisted upon an examination, it would not have passed out of their hands, as they were fully competent to take care of it. Sometimes, however, the fault lies in the incompetency of the physician who is called in to attend a case of metrorrhagia. The following instance will illustrate the very opposite of the circumstances related in the foregoing case.

A poor washerwoman was admitted to St. Mary's Hospital about two years ago, having been treated for so-called ulceration of the womb with hemorrhage for a long time. The attending physician cauterized the cervix every three or four days, and managed to get about sixty dollars of this woman's hard earnings by this treatment. Dr. Wenning, who was on duty at the hospital, immediately made an examination, and detected a fibroid polypus hanging from the posterior lip of the cervix. He removed the tumor, the woman recovered, and, so far as he knew, regained robust health.

Dr. Wenning remarked that he hardly knew how to discuss the subject of uterine hemorrhage — any more than he could the question of "cough." It is merely a symptom, and depends on a great variety of causes. But he would answer the question proposed by the essayist, by saying that if a woman has a protracted hemorrhage, one that is very profuse at a time, or occurs in short intervals, it is much more frequently due to local than general causes. One general cause is the so-called hemorrhagic diathesis, or hemophilia, which is very rare. Also those hemorrhages must be considered constitutional which occur in the course of diseases in which the blood is depraved, as purpura hemorrhagica, scarlet fever, small-pox, etc. Much oftener, however, the cause is local.

The speaker thought also that physicians too frequently, satisfied with the words of the patient, that some such cause as "change of life," etc., is at the bottom of the trouble, fail to investigate the case properly, and prescribe constitutional measures alone. Every woman who suffers from a profuse and protracted hemorrhage must be made to submit to an examination, or otherwise further treatment ought to be declined. It is true that women will often refuse, and the physician must content himself with prescribing in the dark, a practice, however, which is not to be recommended. Sometimes, even when the examination is granted, the case is not treated properly. Thus the case reported by the previous speaker was frequently examined and treated locally by means of applications of iodine. The physician, although, perhaps he recognized the tumor, had hoped to promote absorption of the growth by this means. Here the

fault was not one of negligence, but of ignorance. When the patient was first seen by the speaker, she presented the appearance of a woman suffering from some malignant disease. An examination at once revealed the cause of trouble in the appearance of a fibroid polypus about the size of a peach, partly extruded from the cervix. It was easily removed with a wire ecraseur, the woman was put upon iron and other tonics. She is now a perfectly healthy woman, weighing nearly twice as much as she did a few years ago. He was especially impressed with this case because it was one of the first that came under his notice when he became gynecologist to the St. Mary's Hospital, and was the first case operated on by him at that institution.

Dr. Reamy said that his friend who had just spoken had taken occasion to arraign general practitioners for want of examination in making out a diagnosis, or in failing to find the facts when an examination is made. The speaker was constrained to offer a mild protest in behalf of the general practitioner. He did not believe that the profession is usually to blame. The patients have not always been treated as they said they were by the practitioner, and subsequent revelations have several times shown the speaker that the patients had not represented facts in their true light. He would cite an example in illustration. A young unmarried woman has had a hemorrhage. She does not know whether it is a true hemorrhage or a hemorrhagic menstruation. The physician hesitates to make an examination right away, prescribes and tells her to notify him if it occurs again. She may have thus two or three hemorrhages and then will be all right again; or, the hemorrhages continuing all along she may fall into other hands, say two years afterwards, and then make a statement that she was not examined, by the first physician, although an examination at that time would not have revealed the cause. The speaker then had a case where a married woman, 35 or 36 years of age, consulted him in reference to a hemorrhage. He supposed either that she was pregnant or had an abortion and proposed an examination if the hemorrhage should occur again, as it was not at the time convenient. This lady then left the city, returned in about a year and then consulted a medical friend, who found a uterine tumor. The speaker was severely censured for not having detected the growth, and simply having deferred an examination. The gentleman who first saw the case wanted the speaker to see the case in consultation, but the family protested against it, charging him with negligence or stupidity.

Another fact must not be forgotten. Many cases, especially fibroid growths, have been so changed from the condition in which the general practitioner found them that when they fall into the hands of the specialist they are easily recognized, whereas if they had been examined at the very first a specialist might even have failed to detect anything. Myom a-

tous growths, interstitial or submucous, are not always easily differentiated. No word terrifies the public so easily as the word "tumor." They are satisfied with any enlargement, as enlarged glands, etc., if it is only not called a tumor. A physician told the speaker that he had a case of noma, a malignant tumor of the mouth; he told the friends that it was an epithelioma, and they said they were glad it was not a tumor.

The speaker believed, however, that nowadays patients will not go long with a hemorrhage without being examined by somebody. If gynecology has done any good, it has at least sharpened the mind of the practitioner to look for these growths and detect them. *Dirty* gynecologists, as Mrs. Livermore calls them, have at least done that much.

The speaker would not proceed any further to discuss the subject of cancer, fibroid tumors, etc., nor whether conservatism be proper or not, as that was out of the range of the present discussion.

Dr. Wenning replied that he did not intend his remarks as an arraignment of the profession in general. He simply wanted to say that if cases were allowed to go on with *protracted or frequently repeated* hemorrhages, an examination should be demanded, and if this was not done, the physician in attendance failed to do his duty. All of the essayist's cases were of such a character that an investigation should have been made earlier. The speaker would admit that even gynecologists would refrain from making an examination in every case where an unusual hemorrhage has occurred but once or twice, and even they may be mistaken at times as to the cause, but at least an examination should be made whenever there is the slightest ground for suspicion of serious trouble.

Dr. Palmer remarked that while local explorations are often neglected or imperfectly made, at the same time a local exploration, as thorough as is possible, will not always reveal the cause of hemorrhage, although it is local. For instance, a very small fibroid, interstitial or sub-mucous, may cause severe and protracted hemorrhage; for hemorrhages are by no means in proportion to the size of the tumors. Careful explorations, digital and by tents, followed by finger within the uterine cavity, may fail to detect the same. Yet, months or years subsequently, as the growth develops and descends within the canal, diagnosis may be exceedingly easy, especially if the examination be made at the time of hemorrhage, when the growth is most apt to descend, and the cervical canal is most open. The most skillful diagnostician may fail very early in the history of such a case, while the merest tyro can succeed later on. It is no reflection on the knowledge of the first, nor any special credit to the skill of the latter, that the former failed while the latter was successful.

The mistake is not an uncommon one to carry on topical treatment to or within the uterus, when the real underlying cause of the hemorrhage resides in the heart, liver, or some of the abdominal organs.

It might be profitable at some time to discuss the therapeutic range—the special adaptation—of some of the best recognized remedies for ar-

resting uterine hemorrhage. Thus, while ergot was the remedy to which we most generally fly, and while it had the widest range of application of any remedy, at the same time there are conditions aggravated by it. Astringents ought to be used but little. Iron generally increases menorrhagic states, but there are cases and conditions more improved by it than by any other remedy. And so on.

It is difficult to disabuse the patient's mind that the uterine hemorrhage is dependant upon the so-called "change of life." Her climacteric period of life is a physiological, not a pathological one. In and of itself alone, it does not create uterine hemorrhage, and when such is present, it is indicative of positive disease of some kind.

Dr. Trush added that since the essayist had put the question to the members whether in their experience the cause of uterine hemorrhage was more frequently general than local, he would say that he had found the local causes much more numerous in the production of hemorrhage than the general or constitutional conditions.

Dr. Reamy agreed that his experience co-incided with that of the previous speaker.

Dr. Illowy concluded the discussion by saying: It is true that when we refer to the sections on tumors of the uterus and their symptomatology in the various text-books on gynecology, we find hemorrhage set forth very prominently. Nevertheless in the chapters on menorrhagia and metrorrhagia it is there stated that these are chiefly due to debility, overwork, etc. My personal experience conflicting decidedly with this latter view, it was to learn the opinion of the members on this point that I brought up this subject; and excluding post partum hemorrhage and that from abortion, the subject is certainly not so vast as might at first be supposed.

Abstracts and Selections.

I.—OBSTETRIC.

Induction of Premature Labor by Electricity.—Dr. J. Syromatnikov, writing in the *Vrach*, on the induction of premature labor by means of electricity, mentions three methods; the external, where one electrode is placed on the sacral region, and the other over the uterus; the internal, in which both electrodes are introduced *per vaginam;* and the combined where both the former methods are made use of. In principle, the author prefers the internal method, but, in the case which he gives, he made use of both external and internal methods. The patient was 26 years of age, and had so contracted a pelvis that perforation had been resorted to in her first labor; so the author, thinking it unsafe to allow her next pregnancy to run its natural course, proceeded, in the thirty-

seventh week, to bring on labor by the use of the primary coil of a Sparner's induction apparatus, with a single element. This produced pains in an hour's time; during the next few days, the electricity was employed for ten minutes at a time, twice daily. Within a week, the os uteri was sufficiently dilated to permit of the introduction of the No. 1 size of Barne's bags. Podalic version was performed, and a living healthy child extracted. The patient recovered satisfactorily. The author thinks faradisation is but seldom used for the induction of labor, but he mentions three cases previous to his own, two by Gruenewaldt, and one by Tipyakoff.

Pregnancy After Double Ovariotomy.—Prof. Schatz, of Rostock, in the *Centralbl. für Gynäkologie*, speaks of a recent paper by Schröder, describing six ovariotomies where the sound part of the ovary had been purposely left behind. Five recovered, but pregnancy had not occurred since the operation in any of them. Schatz, on the other hand, has successfully removed two ovarian cysts, leaving the healthy tissue of both ovaries, pregnancies following the operation. The patient was a single woman aged 20.

On February 20, 1880, Dr. Schatz performed ovariotomy. A large cystic tumor of the left ovary was removed, including the outer third of the Fallopian tube and all the ovarian tissue that could be found. The right ovary was of the size of a walnut, and showed signs of cystic degeneration. It was ligatured by means of three silk threads passed between it and the broad ligament, and cut away in such a manner that a piece of ovarian tumor tissue, at the most but two millimetres broad, was left on the proximal side of the ligature. The right tube remained intact. During recovery, an abscess formed in the track of a suture in the abdominal wound.

On March 21, when the period was due, the patient was seized with a paroxysm of pain in the right side of the hypogastrium and right thigh, with vomiting and high fever for four days. The symptoms recurred on April 8, and again on May 8, when the pain extended to the left hypogastrium. No deposit could be detected in the pelvis. The first 'show' appeared on May 9; it lasted three days and was pale and scanty. It recurred on May 31. In the interval, attacks of pain occurred in the left inguinal region.

On June 11 a swelling, of the size of a plum, was detected behind and to the left of the uterus, which was strongly antiflexed.

On June 28 severe sacral pains set in, radiated to the left inguinal region, and disappeared at the period, which was copious, and lasted for six days.

On July 15 the uterus was found to be small and retroverted. Henceforth the catamenia appeared regularly up to the patient's marriage in

April 1884. At the beginning of August the last period was seen before pregnancy, the symptoms of which became marked in September.

On May 12, 1885, labor set in; it lasted thirty-six hours, and the forceps was employed. The right ovary had been preserved, and the cut surface was examined: it was found to be undoubted ovarian tissue, containing Graafian follicles. The tumor of the left ovary was also subjected to fresh examination, and it was found that the entire organ had been removed. [This remarkable case throws a light on the nature of pain proceeding from ovarian disturbance, for the pain described in this case is rare after ordinary ovariotomy. It also proves the necessity of a very thorough removal of the ovaries when oöphorectomy is performed for the cure of bleeding myomata of the uterus. It is evident that the fimbriæ of the Fallopian tube can lie in contact with a mere trace of ovarian tissue, as well as with an entire ovary].

Management of the Membranes in Natural Labor.—Prof. G. A. Moses, of St. Louis, read a paper on this subject recently to the Medico-Chirurgical Society. In opposition to the usual practice of rupturing the "bag of waters" at an early stage of labor, as say, when the os is well dilated, Dr. Moses urges that the membranes be left undisturbed. He says: "Some years ago I determined to await in every case, when there were no contraindications the spontaneous rupture of the bag of waters, with the chief object in view of observing the effect upon the vaginal and perineal tissues, and while in but few cases have the membranes protruded beyond the vulva, I think these have indicated that their integrity was of value, and my object in presenting the subject to your attention is to elicit your opinion and experience, and at the same time to urge that each one will pursue the investigation as opportunity shall afford in order that a reliable result may be arrived at. May not the fact be, that, as in other points of practice, we have set aside the teachings and practice of the earlier writers to our disadvantage?"

Dr. Moses also thinks that the elastic wedge of the bag not only serves to dilate the os uteri, but is of great value in protecting the vaginal tract from any sudden impact or prolonged pressure of the head presenting. The paper calls attention to the temporary paralysis of the neck of the bladder, resulting in painful catheterization or inability to void urine, resulting from prolonged or severe pressure against the bladder walls or urethra. "These would, I believe, be very rare, if the membranes could be preserved until the vaginal canal and outlet could be in good degree dilated before the head itself would reach the obstructing site."

Very much of the objections made by this paper, is answered by the fact that the "bag of waters" is spontaneously ruptured, before any service can be rendered in dilating the vagina and vulva.

Another point Dr. Moses makes is worthy of considerable consideration: The expressed object of artificial rupture is the acceleration of labor. Under ordinary circumstances, that is in cases of "natural labor," should labor be accelerated? He says—Decidedly not; particularly first labors; let the membranes alone,—if they do render labor a little slower than attendant or sufferer might desire, the slowness is a part of safety, and it is in the power of the accoucheur to hasten if impending danger demand haste.

Treatment of Puerperal Eclampsia with Hot Baths.—Breus (*Arch. f. Gyn., Rev. med. franc. et etrang.*) reports that he has continued his experiments in the use of hot baths as a remedy for puerperal eclampsia, and has now treated seventeen patients by that method with only one death. If there is albuminuria, that too is favorably affected by the baths. He first puts the patient into a bath of about 100°, and gradually carries the temperature up to 104° or 106°. He has not found that either abortion or hemorrhage is favored by this treatment.—*New York Medical Journal.*

Physiology and Management of Placenta Previa.—(Robert Barnes, M.D, F.R.C.P., in *Medical Press.*)

The very interesting papers on Placenta Previa of Drs. Murphy and Braxton Hicks (*Medical Press*, Sept. 2 and 9, 1885) fitly call attention to the practical modes of dealing with a complication of pregnancy, which, until the publication of my Lettsomian Lectures, and my Lectures on Obstetric Operations, had been regarded as one of the gravest dangers in obstetrics.

Dr. Murphy and Dr. Hicks have discussed the subject of treatment chiefly upon the empirical ground of the value of particular measures, that is, dilatation of the cervix uteri, detachment of the placenta from the lower segment of the uterus, and the bi-polar method of turning. These proceedings are all of proved value. But rightly to apply them in order, time, and manner, we must seek for our guide in the physiology and natural process of placenta previa. In this way we shall arrive at a method at once rational, and in the best sense empirical.

The theory of placenta previa first enunciated by me in 1847, developed more fully in my Lettsomian Lectures, 1857, in my Lectures on Obstetric Operations, 1870, and in the "System of Obstetric Medicine and Surgery," by myself and Fancourt Barnes, 1885, has stood the severest tests of clinical experience and keenest criticism. The memoir of Dr. Murphy bears direct clinical testimony to the principles I have laid down. He gives a series of 25 cases treated without a death. In the summary of 69 cases observed by me down to 1864, and quoted by Dr. Murphy, there occurred a series of 29 cases without a death. I think it may be safely affirmed that these results are in striking contrast

with all previous records. This is eminently a case in which successful therapeusis proves the truth of the theory upon which it is based.

But recently a remarkable confirmation of this theory comes from an independent authority, working from a distinct point of departure. By a process of physiological reasoning and clinical observation I had demonstrated that the uterus presented three zones differently endowed; that the lower zone was the true seat of placenta previa; and that there was a physiological line of separation between previal and lateral placenta. This lower circle or physiological boundary line between safe and dangerous placental attachment has been demonstrated (1876) anatomically by Bandl. Thus clinical, anatomical, and physiological study confirm each other, and concur to demonstrate what really constitutes placenta previa.

Parvis componere magna, may I, with unbounded veneration for the illustrious discoverers of the planet Neptune, recall the history of that discovery in illustration of the more modest history of placenta previa? There is this point of similarity: In both cases the physical demonstration was preceded and indicated by theoretical research and induction. The calculations of Adams and Leverrier to account for the aberrant motions of Uranus made certain the existence of a planet whose mass and place in the heavens they described with such precision that Galle, turning his telescope to the spot, actually saw it. To resume my argument. The rational management of a case of placenta previa depends upon the observance of the law that hemorrhage frequently ceases when all the placenta that is strictly previal is detached. Not that this detachment is always sufficient *per se*. Concurrent contraction of the uterus and other factors are necessary, and several measures must commonly be called into action in aid of the efforts of nature, in combination or succession. Let us take these in order. Assuming, first, a case in which serious hemorrhage is going on, whilst the cervix uteri is not dilated enough to admit the finger, we have a choice of two proceedings — 1, to puncture the membranes; or 2, to dilate by my bags. The puncture is often the best thing to do first; and this because in many cases it is sufficient to arrest the hemorrhage. The uterus under its retractile or spring-like energy of form-restitution detaches the placenta from its dangerons zone, and closes the bared uterine vessels. It is a proceeding that can be adopted even at the earliest stage, before other methods can be executed.

2. Take a case where the bags can be used at once. Dilatation by their help may be made before rupturing the membranes. There is rarely much bleeding while the bag is *in situ*; the intra-uterine portion presses upon the lowest portion of the bleeding zone; it provokes uterine energy, and thus having opened the way, we proceed, thirdly, to the essential measure of detaching by the finger the placenta from the lower zone of the uterus. This accomplished, the hemorrhage will often stop, and it may be wise to wait awhile. But if bleeding continue, proceed, fourthly,

to the delivery of the child. This is generally best effected by Hick's method of bi-polar turning. The placenta is then expressed. And should hemorrhage still continue, uterine contraction failing, the course is to inject, first, hot water, and, that failing, a solution of perchloride of iron, the uterus being compressed by the hand. The case is now one of ordinary post partum hemorrhage.

It thus appears that no one proceeding is *the* proper method of treatment, but that several proceedings are pressed into service according to indications. The one of prime necessity is detachment of the placenta. Turning comes in occasionally and incidentally. And here I may remark that Dr. Murphy's reproach that Hicks' method has found less favor in England than abroad is hardly correct. I took great pains by making special illustrations to call attention to its merits, and confirmed his claim to originality in the first edition of the Obstetric Operations in 1870. I there particularly said, referring to placenta previa, that "the bi-polar method here finds one of its most valuable applications." Since then the method has been fairly recognized by Leishman and Playfair. Hicks' own illustrations are given in Lusk. It is referred to with less approbation in German and French text-books. Spiegelberg is especially behind the day in the application of this method to the treatment of placenta previa. And indeed the teaching of this author is distinctly retrograde—he would carry us back to the *accouchement forcé*.

His first step is to wait, hoping the bleeding may stop, and the period of instant danger be tided over until the normal term of gestation is reached. "But if the bleeding continue or becomes profuse, we must step in and *deliver as quickly as possible by turning and extraction.* The delivery is now often remarkably quick, when the cervix seems but slightly canalized, in virtue of its great relaxation and the slight development of the musculature at the lower segment of the uterus, especially in pluriparæ. One must not be frightened by the word '*accouchement force*,' since it is mostly found on trial to be very little forcible."

This is the old purely empirical treatment under which so many disasters have occurred, and which made placenia previa a word of terror.

II.—GYNECIC.

Laparotomy for Intestinal Obstruction: The Mode of Operating. — By J. Greig Smith, M.A., F. R.S.E., in the *British Medical Journal.*

An abdominal section for obstruction of the bowels is usually a very different proceeding from one for removal of a tumor. In the former case the abdominal walls will be hard, tense and unyielding, and the intestines will be full of fluid and gas under considerable pressure. When the abdomen is opened and the pressure is partly removed, the gas expands, dilating the bowels and forcing them through the wound. In or-

dinary cases of laparotomy, where the gut is flaccid and empty, it is easy enough to isolate and run our fingers along it for a considerable distance; in cases of obstruction this is a matter of great difficulty. The gut when distended is too large to be easily grasped between the fingers; its walls are too thin and impalpable to be isolated by mere touch, and if any degree of peritonitis be present, it will inconveniently stick to the fingers. The exploring hand at every step is caught in the loops of distended bowel which wind about in most confusing manner inside the abdominal cavity. In fact, it is when the physicial conditions are most strongly against us that we have to look for the cause of an intestinal obstruction inside the bowel.

A course of procedure has been laid down for our guidance in such cases, and it would be well for you always to follow this course. Though I have not yet derived any help from it, it is not unlikely to be of good service in leading us to the seat of obstruction. The plan is as follows:

First carry the hand to the cæcum; if it be found distended, the obstructing cause will probably be found somewhere in the large bowel below this, and the hand is carried up the ascending colon, across the transverse colon and down the descending colon as far as the sigmoid flexure, seeking for the stricture all the way. If the cause be not here, we are then told to carry the hand from left to right under the distended coils, seek for collapsed bowel, and follow it up till we meet with distension, when we shall probably find the cause. Now it is much easier to lay down these directions than to put them into practice. If the small intestine be much distended with gas we may have the transverse colon pushed up under the ribs; and to reach it there, over coils of distended gut, under hard, brawny, abdominal walls, and more than this, to isolate it and diagnose its condition, is an undertaking, to say the least of it, of very considerable difficulty. If we can find undilated bowel we can follow it up easily enough, but how often do we expect to find empty bowel in these cases? I have not yet met with it. We must be prepared to find the bowel everywhere dilated, at some parts more than others, but nowhere collapsed, and we must be prepared to look for the obstruction amid the endless contortions of these soft, sticky and dilated coils.

As I have said, I have always observed these directions, but only to find the observance so much valuable time wasted. To proceed to examine inch by inch the whole length of bowel will probably be successful so far as discovery of the site of obstruction is concerned, but not probably so as regards saving the life of the patient. In such a procedure the amount of rough handling and the length of time spent over it, must tell seriously against the chances of recovery.

The plan I would recommend to you is this: The most distended portions of bowel are usually nearest to the surface; move these about gently and fix upon any part that appears to be more congested than another.

Follow this part in the direction of increasing congestion down into the cavity, wherever it may lead. If, now, the cause be discovered it may at once be treated. If not, I would then recommend a plan which has been almost universally condemned; that is, to permit the bowel to extrude. The wound is covered with some layers of fine cloth, or better still, by a large flat sponge wrung out of warm carbolic or boric lotion, and covered with gutta-percha tissue to prevent evaporation and cooling, and the most distended coils are coaxed out under this covering. Carefully watch the gut as it comes out. One end of the coil will be more distended than the other, and will come out less readily, and this end will usually be more injected than the other. As they continue to extrude these differences will be more marked, and we will be able satisfactorily to decide that one end of the coil is nearest the cause of obstruction. We follow this end wherever it leads, it will certainly lead us to our goal. I have three times followed this course and been charmed with its simplicity and efficiency.

Turning to the extruded coils of bowel the bulk that they assume may look somewhat alarming. If the distension be not very great, you may try to return them. Spread the hands over the warm antiseptic covering, gather the bowels together, and by steady, gentle, equable pressure send their contents into the bowels that lie inside the abdomen. When they are nearly emptied and occupy about one-fourth their previous bulk they may be slipped through the wound, while an assistant, with finger hooked in at each extremity, pulls the opening forward. The abdominal wall is, so to speak, pulled up over the bowels. A flat sponge is now laid over them to protect them and keep them in position while the wound is stitched up.

But it is by no means certain that we are always right in thus closing up an abdominal wound over distended bowels. In fact, I believe that in doing so we are nearly always wrong. I believe that this distension is in itself a serious factor of the malady. It certainly acts as an obstruction. I place before you these coils of intestine with the mesentery attached, just removed from a dead body. They are filled to distension with fluid and confined within the walls of this dish. You notice that the gut forms acute flexures, and at each of these the mesenteric side of the bowel is pushed in and acts as a sort of valve, blocking the calibre of the gut. As with any other tube, if you bend the bowel acutely enough you block its passage. Inside the abdominal cavity, where the confinement is greater, the flexures are more acute and more numerous than those on the table, and you may easily satisfy yourself by experiment that the passage of its contents is even more difficult. Practically this fact explains why we are so often disappointed with the effect of tapping the bowel to permit the escape of gas or fluid. We empty it down to the first or second flexure and no farther.

Such distension also has an injurious effect on the bowels themselves. An intestine that has been overdilated for hours, perhaps days, and that is probably partly paralyzed by opium, we should expect to contract on its contents no more than a dilated bladder under the same circumstances. If it cannot pass its contents along, the obstruction is to all intents and purposes unrelieved. We know that such increase of pressure inside the abdomen is, partly from its physical effects upon the diaphragm, and partly no doubt, through injury to the sympathetic ganglia, a cause of serious illness. When added to the effects of intestinal obstruction, its gravity is increased tenfold.

Now it is a matter of constant experience that free vomiting greatly relieves the patient. I am one of those who do not lightly regard the experiences of our forefathers, and I cannot believe that the very general esteem in which from the days of Hippocrates and Praxagoras they held the use of emetics in obstruction, was utterly misplaced. And quite recently we have had recommended strongly by Kussmaul the removal of gasses and fluids in these cases by the use of the stomach pump. Relief is always claimed for this procedure, and, in not a few cases, positive cure.

I certainly consider the removal of this fluid and gas from the bowels after the relief of the constriction, as the most important detail in treatment. If it is to be done it must be done rapidly, for no time must be wasted in these operations. Tapping will not do, for the flow through such a trocar as we should dare to push through the abdominal wall would be far too slow. We must incise the bowel. The blade of an ordinary scalpel, making a wound about one-third of an inch in length, is pushed through the bowel transversely, at the point farthest removed from the mesentery, and while you hold the opening, removed as far as possible from the wound, over a receiver, an assistant presses the sides of the abdomen and squeezes out the intestinal contents. At first, probably there will be a rush of gas, and then fluid will follow, watery or fæcal, as the case may be. When the abdominal walls are flaccid and the intestines nearly empty, we may stitch up the wound in the bowel, return it and close the abdomen.

You have just seen this proceeding carried out in one case. The patient was in about as bad a condition as ever one sees upon an operating table. His pulse could scarcely be felt and certainly could not be counted. His intestines were everywhere of a bright rosy red, covered in many places with patches of yellow lymph, and everywhere fully distended. Semi-purulent fluid flowed from the abdomen when the incision was made and a good deal more was mopped out. The constriction, a mesenteric band, was discovered in the way described, and easily divided. The bowel was incised, and through the opening, while the abdomen was being kneaded, large quantities of gas and fluid escaped. A contin-

uous suture of fine catgut accurately closed this opening; the bowel was easily returned; the abdomen was wiped out, and the wound sutured in flaccid abdominal walls. You have seen the case recover with no more trouble than any other abdominal section, with less trouble, certainly, than most cases of herniotomy. One example is more impressive than much advice. I am sure you will not soon forget the lessons which this case has taught us.

In conclusion I venture to submit to you these rules for your guidance in opening the abdomen for the relief of acute intestinal obstruction:

1. Make the incision in the middle line below the umbilicus.

2. Fix upon the most dilated or the most congested part of the bowel that lies near the surface and follow it with the fingers as a guide to the seat of obstruction.

3. If this fail, insert the hand and carry it successively to the cæcum, the umbilicus and the promontory of the sacrum.

4. If this again fail, draw the intestine out of the wound, carefully covering it, until increase of distension or congestion or both in one of the coils gives an indication that the stricture lies near.

5. If there be considerable distension of the intestines, evacuate their contents by incision and suture the wound. Never consider an operation for intestinal obstruction inside the abdomen finished until the bowels are relieved from over distension.

6. Be expeditious, for such cases suffer seriously from shock. The whole operation ought to be concluded in half an hour.

A Case of Inversion of the Uterus of Three Years Standing, Reduced in Twenty Minutes by Dr. Emmet's Method.— Dr. Edmond Souchon, writes as follows in *The New Orleans Medical and Surgical Journal:*

So very many cases of inversion of the uterus give so much trouble to reduce them, that it is most gratifying, comforting, and especially encouraging, to come across one that gives no trouble at all.

The following are the particulars: Mrs. B., aged forty-five, has had *thirteen pregnancies*, three of which terminated in miscarriages. Three years ago, she was delivered by *a midwife* of a fine healthy child at full term. As soon as delivery took place, there appeared outside of the vulva, a tumor which bled profusely. A physician was sent for, who recognized the trouble to be inversion of the uterus. He made some attempt to reduce it, but not succeeding as readily as he wished or as he thought he should, he became alarmed at the great loss of blood, applied astringments and pressure to the great tumor and informed the patient and her husband that later on some new attempt should be made to remedy the trouble. The blood ceased and the tumor diminished in size so that in course of time, it was not visible at all outside. This reassured the patient and she let things go on. At her menstrual periods, how-

ever, and sometimes also between them, she lost much blood, she became very sallow, puffed and had an anemic murmur at the base of the heart.

At this time Dr. G. Devron was called in, and as he judged that some surgical interference was indispensable, he asked that another confrere be called in with him, and I was the one selected.

At first, the examination was not very satisfactory, the parts being tender, the abdomen tense and the vagina so easily elongated when the finger was pushed up to try to pass behind the tumor, that it was not easy to do so. The tumor was about two inches long, with a body about one inch and a half in diameter. However, the finger, passed around the groove between the pedicle of the tumor and the cervical canal, was quickly arrested and could not penetrate any higher than at most a quarter of an inch. To make sure our diagnosis, we determined to recognize the characteristic *indentation* corresponding to the point of inversion of the uterus. To accomplish this, the tumor was seized with a vulsellum forceps and by gentle traction, brought as low down as possible; this, however, did not bring the tumor any further out than the orifice of the vulva. The tumor being held there, it became an easy matter for the finger to feel, through the posterior vaginal cul-de-sac, the *pathognomonic indentation;* the finger introduced afterwards into the rectum, felt the indentation even better. To be doubly sure, the body of the womb was searched for in front, behind and at the sides and could not be found. The case was therefore positively and unmistakably an uncomplicated inversion of the uterus of three years standing.

We informed the patient and her husband of the nature and difficulties of the case and told them that the patient would have to be put under chloroform, and efforts made during two and three hours, to try to return the organ to its proper place and shape; that this should be done every day for eight or ten days possibly, unless the patient's condition prevented it. Accordingly, the very next day the patient was thoroughly anæsthetized by Dr. Devron; this relaxed completely the abdominal walls. With my left hand introduced into the vagina and my right hand on the abdomen, I had the whole organ fully under control. The first impulse and temptation in these cases, is to press against the base of the tumor, I confess to have yielded to it, though expecting little from it. As this flattens the tumor, as the pressure shoves the vagina upwards, the first impression also is that the tumor has been somewhat reduced, but the moment all efforts cease, it is immediately found out that it is not so. I therefore, determined to lose no more time at his and at once to apply Dr. Emmet's method.

I introduced the thumb and fingers in the groove between the pedicle of the tumor and cervical canal extending them as much as possible; at the same time, I exercised all the pressure I could upwards, against

the *bottom* of the groove and with the palm of the hand, I endeavored to push the tumor itself upwards. Simultaneously with this internal manœuvre, the end of the fingers of the right hand placed over the abdomen could feel distinctly the indentation and were made to press successively all around the smooth margin of the *indentation*, trying at the same time to work these fingers from the inner lip of the indentation to the outer lip, so as to unravel it, as it were. After seven or eight minutes. I had accomplished nothing and my left hand got very tired. Dr. Devron took my place, and I took charge of the chloroform. After working in the same manner for about seven or eight minutes, his hand became so cramped, that he had to desist, without having accomplished any good apparently. I, then, resumed the same efforts and was about removing my hand from fatigue, when all at once, I felt one point of the circumference yielding a little, then more, and finally in the space of a minute, the whole tumor was reduced. My index and middle fingers were pushed into the fundus of the uterus as high up as I could stretch the uterine walls as much as possible in their newly conquered position, and with the fingers of the right hand on the abdomen, I gave them and the fundus a good squeeze, as I would a folded piece of thick, wet and softened leather to make it keep its fold. Dr. Devron then made a thorough examination and pronounced every thing all right. Thus, in the short space of twenty minutes, a complete inversion of the uterus had been reduced. We were very agreeably disappointed at our most unexpectedly rapid success, and were much delighted for our poor patient and also for ourselves.

One remarkable feature is that the moment the resistance began to yield, it yielded so rapidly that the whole reduction was in truth accomplished in a minute's time. This quick reduction was the last thing expected, specially in a case of three years standing. I am at loss to explain this. Of course, it is because the tissues were not so hard and so firmly contracted as in the vast majority of cases, but why so in this case? Very likely because the numerous previous pregnancies and the age of the woman had reduced the contractility or tonicity of the uterine muscular fibres.

The patient made a rapid recovery.

III.—DISEASES OF CHILDREN.

Indigestion in Children.—Wm. H. Hale, M.D., in the *Polyclinic*.

Children are particularly prone to diseases of the digestive apparatus, and the most prevalent form is indigestion.

During the summer especially, owing to the extreme heat and the ingestion of food entirely unsuited to the age of the child, is this the case.

Very frequently on questioning the mother as to whether she had given anything but the breast to an infant of a few months, I have been informed that she gave it a taste of meat, potato or other article which it is unable to assimilate. The gastric and intestinal secretions are not of sufficient quality or quantity to affect their digestion, consequently they lie in the stomach acting as an irritant, and ultimately vomiting takes place. Previous to the occurrence of vomiting fermentation develops, and the injected matter is of an extremely acid character. It seems entirely beyond her comprehension that she is giving a poison to the child and is slowly starving it, from the fact that the absorbents are unable to supply the wants of the economy.

On first seeing a child with an attack of indigestion, one may be puzzled as to what the affection is. We generally find the child, who but a few hours previous was bright and playful, now listless, languid, lying down, with no interest in his playmates, eyes bright and feverish-looking, skin hot and temperature high, rising in a few hours to 100° F. The fever generally continues until the removal of the irritating matter from the stomach, when rapid defervescence occurs. Sometimes there are small, diarrhœal stools, but more frequently constipation exists. If the child is old enough to express itself, it will complain of headache, excessive thirst and nausea. Vomiting generally occurs.

Extreme prostration occurs and the patient becomes limp from the severity of the symptoms. Coldness and chilliness are at times complained of, but this is only transient, and is soon succeeded by extreme heat. Vomiting is at times severe, and large amounts of food are expelled from the overloaded stomach, in the same condition as when it was eaten; accompanying it is some mucus, and at times bile. After the expulsion of these matters and the free evacuation of the bowels, the symptoms quickly subside and a return to health takes place.

The causes of this affection are numerous, but I will only mention a few which are especially prevalent in the hot season.

The ingestion of large amounts of fruit or vegetables, and particularly corn, no doubt from its known indigestible qualities, and large draughts of icewater, which chill the stomach, preventing digestion, are the most frequent causes, and the ones which have come most frequently under my notice. At times we find it due to too frequent nursing, the child being given the breast every time it cries, if that is every five minutes during the day. Children should be nursed for an interval of two hours for the first few months, and as they get older it should be increased in length.

The treatment is extremely simple so soon as we are positive that it is indigestion. I find a calomel purge, together with a fever mixture, all that is necessary. Quinine is one of the best fever depressants, as it also combines tonic properties. The regulation of diet, together with the above measures, and subsequently a tonic, is all that is necessary to complete recovery.

The Treatment of Whooping Cough.—In his summary of treatment, in a clinical lecture delivered at the Philadelphia Hospital (*Medical News*), Dr. John M. Keating emphasizes the value of the steam spray and the atomization of medicated solutions, among which he ascribes value to Dobell's solution, eucalyptol, and thymol. With the bichloride he advises caution. Corrosive sublimate, which is now used for almost everything, he says, has also been applied here in the form of the spray. He remarks that it is a dangerous drug to put into the hands of an inexperienced person, and, as we have so many other useful remedies for this affection, he thinks it wise to avoid the use of corrosive sublimate. He has used listerine extensively with good results in the treatment of whooping cough. He employs it in the strength of one drachm to two ounces of water, with an ordinary hand-atomizer, directs the nurse to apply it twelve or more times a day, and finds that little children, even babies, do not object to it. He adds to it tincture of belladonna, potassium carbonate, or ammonium bromide, as the case may demand. Chloride of ammonium he also finds of great service in the form of spray. —*New York Medical Journal.*

Gossip.

Dr. Robert Battey has averaged one ovariotomy a week since January 1, last. The largest tumor weighed when removed fifty-six pounds. Not one case has terminated fatally. The doctor attributes this success in a great measure to antiseptic precautions which he adopts. The editor of the *Atlanta Medical and Surgical Journal*, who has recently visited Dr. Battey, thinks it is due in greater measure to the careful and skillful nursing of Mrs. Battey.

The Ovariotomy Record "Broken."—Mr. Lawson Tait reports a series of one hundred and twelve operations for ovarian and parovarian cysts without a death. These operations were performed between January 1, 1884, and August, 1885. All the operations were completed. They were performed without Listerism. This settles forever, for Mr. Tait, the question of the utility of Listerism.

WASHINGTON OBSTETRICAL AND GYNECOLOGICAL SOCIETY.—At the annual meeting of the Washington Obstetrical and Gynecological Society, held on October 16, 1885, the following officers were elected for the ensuing year:

President, Dr. A. F. A. King.

Vice-Presidents, Drs. W. W. Johnston and J. Taber Johnson.

Recording Secretary, Dr. C. H. A. Kleinschmidt.

Corresponding Secretary, Dr. S. S. Adams.

Treasurer, Dr. J. B. Harrison.

Committee on Business, Drs. C. E. Hagner, Lachlan Tyler and S. S. Adams, (ex-officers.

Committee on Admissions, Drs. G. N. Acker, H. H. Barker and H. D. Fry.

Committee on Publications, Drs. T. C. Smith, J. R. Bromwell, and Kleinschmidt.

Committee on Pathological Specimens, Drs. Acker, G. W. Johnston and Harrison.

VERY IMPORTANT — REDUCTION IN PRICE OF ANDERSON'S VAGINAL CAPSULES.—By recent improvements in the manufacture of Anderson's Vaginal Capsules, we can now offer them to physicians at 60 cents per box. Corresponding reduction to the trade.

We also take pleasure in announcing that we have greatly improved the Capsules and they are now without doubt the most efficient and convenient means for making local applications in the treatment of female diseases. Circulars on application. Write for quotations for quantities.

HALL & BAILEY,

Manufacturers of all Kinds of Capsules, Indianapolis, Ind.

THE WESTERN SUPPOSITORY COMPANY, 91 Washington street, Chicago, are manufacturing an excellent line of Bulb Suppositories. A Revised List of Formulas sent free on application. Their medicated wafers are pronounced a great success by the profession.

Bibliography.

Elements of Modern Medicine. Including Principles of Pathology and Therapeutics, with many useful memoranda and valuable tables for reference. Designed for the use of Students and Practitioners of Medicine. By R. FRENCH STONE, M.D., Professor of Materia Medica, Therapeutics and Clinical Medicine in the Central College of Physicians and Surgeons, Indianapolis; Physician to the Indiana Institute for the Blind; Consulting Physician to the Indianapolis City Hospital; Member of the Marion County and the Indiana State Medical Societies.

Still they come—these *vade mecums*. The market has long been overstocked and the press has raised its voice against their continued multiplication. But the generous desire to assist the poor student in his cramming process is so strong in the professional breast, the itching for authorship, has become so epidemic that nothing can stay the tide.

Every man must write his book. Some men write original books—the rest compile "manuals", "pocket physiologies", *et id genus omne.*

In this volume we have the elements of medicine, put up in one compact volume, in flexible binding, for the pocket. The physician on his rounds may now, like Napoleon on his campaigns, carry a library with him. He has the advantage over the great general in being able to carry it in his side pocket.

The typographical work is very well done. The type, though fine, is very clear; the paper thin but strong. By this means the author has been able to condense into 368 pages a great deal of information and still have a compact volume. It has the fault, common to all these *multum in parvo* books, of giving piecemeal information. Perhaps not a fault if these works are used for the purpose for which they are designed —as outlines for reviewing subjects already studied in text-books or monographs.

The General Introduction is a very fair review of the recent progress and present condition of medical science and medical practice.

The author is a non-believer in the germ theory and takes pains to inform us that the *bacillus tuberculosis* of Koch is "fast losing its diagnostic and prognostic significance." (?)

The work is divided into two parts: Part I. General Pathology. Part II. Materia Medica and Therapeutics.

Part I. discusses etiology, anatomical changes, diagnosis, prognosis, treatment, etc., and closes with a chapter on "Miscellaneous Topics," which may be found useful for reference. The relations in which medical men stand to the law, the professional conduct of physicians, the method of conducting post-mortem examinations and medico-legal examinations are some of the subjects included. There are also a number of statistical tables, and last, but not least, a table of fees taken from the "Fee Bill of the Philadelphia College of Physicians," and the "New Table of Fees of the Medical Society of New Jersey."

In Part II. the classification of drugs is essentially that of Prof. Biddle. It gives the usual phisological and toxicological tables. A "Clinical Retrospect follows which aims to give "the salient points of treatment of the more common and important diseases."

For the student who wishes a pocket *remembrancer*, easily carried and covering a wide range of subjects, we can recommend this in preference to most other books of the kind. The practitioner, we imagine, can invest the price of the work much more profitably. E.W.M.

A System of Obstetric Medicine and Surgery, Theoretical and Clinical. For the Student and Practitioner. By ROBERT BARNES, M.D., Obstetric Physician to St. George's Hospital, etc.; and FANCOURT BARNES, M.D. Philadelphia: Lea Brothers & Co. 1885.

The authors of this new work on Obstetrics are so well known, the father especially occupying so distinguished a place in this department of medicine, that we naturally expect a contribution more than usually noteworthy.

"To write a fairly complete systematic treatise on any branch of medicine demands from the writer a wide experience of his own, a large acquaintance with the work of others, considerable industry, and a critical faculty that will enable him to draw sound conclusions and precepts from his survey of the subject."

We think no one will lay to Dr. Barnes the charge of egotism when he claims that he has "travelled, in practice, teaching, discussion and writing, almost over every step of the ground."

In the preparation of the work, Robert Barnes contributes gestation, puerpery, the mechanism of labor, and of hemorrhage. The son, Dr. Fancourt Barnes, gives the prophylaxis of puerperal diseases, and the description of the operation.

Credit is also to be given to other co-laborers; thus the science of *embryology* is very thoroughly treated by Prof. Milnes Marshall. What we know in *teratology* is prepared by Mr. Noble Smith, who is evidently well fitted for his part.

The reader will have occasion to thank the American publisher for the superior manner in which the book is gotten up; so too the illustrations are very excellent, many of them new, and expressly prepared for this work.

Altogether we find great pleasure in commending so excellent and thorough a book to the profession.

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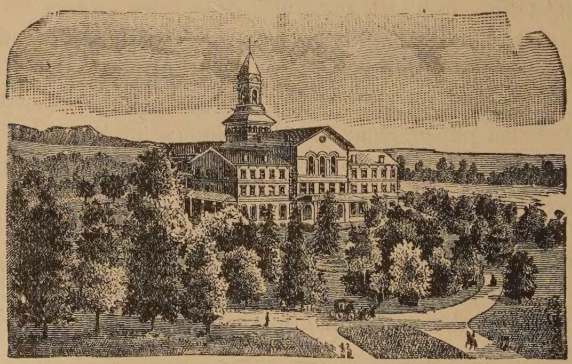

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